DIGITAL OPF
OPF Document Sample with Data Elements

RECOMMENDATION FOR CONVERSION TO CAREER APPOINTMENT UNDER REGULATION 315.703a

INSTRUCTIONS TO EMPLOYING AGENCY: (1.) If all of the applicable items in PART A can be answered affirmatively from av ailable records, the appointing officer may effect conversion to career appointment without referral to the Civil Service Commission. (2.) If item 6 or PART A cannot be answered affirmatively or verified, complete PARTS and B and the indicated items on the reverse IN DUPLICATE. Submit the form in duplicate to: (a) If for verification of an eligible rating, to the Civil Service Commission Office (or Interagency Board of Examiners) from which it is claimed that the rating was issued; (b) If for a noncompetitive examination, to the Commission Office (or Interagency Board of Examiners) which normally recruits for the position held by the employee on the date of recommendation. This form is to retained as a permanent record in the employee's Official Personnel Folder. The original of any copies furnished to the Civil Service Commission office or Interagency Board of Examiners will be returned for that purpose.

PART A. RECOMMENDATION FOR CONVERSION AND DETERMINATION OF EMPLOYEE'S ELIGIBILITY

Name of Employee (Last) (First) (Middle or Initial) **[77, 78, 79, 821]**	Birth Date **[468]**

The employee named above is recommended for conversion to career appointment under CS Regulation 315.703a. This employee is serving in a competitive position under an indefinite appointment (or as a status quo employee)., or under a temporary appointment pending the establishment of a register (TAPER) and his (or her) work performance for the past twelve months has been satisfactory. He (or she):

[232] ☐ 1.. Has completed a total of a least three years of service in a competitive position under an indefinite or TAPER appointment or as a status Quo employee without a break in service of more than 30 calendar days or without an interruption by nonqualifying service of more than 30 days.

[233] ☐ 2. Would have met the service requirement in Item X, above, except that he left a competitive position held under an indefinite or TAPER appointment or as a status quo employee to enter the armed forces and was reemployed under one of these appointments within 120 calendar days after separation under honorable conditions from the armed forces.

[51] ☐ 3. Meets the citizenship requirements.

[231] ☐ 4. Meets the members-of-family requirements (this box must be checked if the employee is not entitled to veteran preference).

[230] ☐ 5. Meets Commission qualification requirements for the position held at time of recommendation.

[229] ☐ 6. Within the last five years was rated eligible in a civil service examination or his name appeared on a civil service register either of which was appropriate for filling a position he held during his qualifying service. The relevant examination and position are stated below.

Title, Date, and Location of Examination **[913, 485, 474]**	Position Title, series, grade (or level), and salary **[81, 117, 115, 661, 152]**

Signature of Agency Official **[138]**	Title **[84]**	Date of Recommendation **[486]**

PART B. REQUEST FOR COMMISSION ACTION OR VERIFICATION

Attach a completed Standard Form 57 to all requests.

[236] ☐ Request verification of employee's claimed eligible rating (s) in the following examination(s):

Title of Examination **[913]**	Civil Service Office & Location Where Examination application is Filed **[13, 473]**	Place of Examination **[474]**	Date of Examination **[485]**

CSC FORM 648

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Verification of the claimed rating(s) would qualify the employee in a position he held during his qualifying period of service. **[235]** ☐ Request arrangements be made for noncompetitive examination of the above named employee for the position of **[82, 156, 118, 116, 171, 662]**________________ (Enter position title, series, grade (if any), and salary held at time of recommendation.) Attach a statement of duties or position description if a positon title is not self-explanatiory.		
Signature of Agency Official **[57]**	Title **[83]**	Date **[484]**

INSTRUCTIONS TO REQUESTING OFFICE: When this form is submitted to the Civil Service Commission, submit it in duplicate. Complete all apllicable items in Parts A and B. Complete both address boxes below and enter the employee's name and birth date in Part C.

TYPE OR PRINT THE NAME, ADDRESS AND ZIP CODE OF THE CIVIL SERVICE COMMISION OFFICE OR INTERAGENCY BOARD OF EXAMINERS TO WHICH THIS FORM IS BEING SENT.

[18, 472]

PART C. COMMISSION ACTION ON AGENCY REQUEST IN PART B		
Name of Employee (Last) (First) (Middle or Initial) **[77, 78, 79, 821]**		Birth Date **[468]**
[234]☐ 1. The employee name above meets the examination standards for conversion under CS Regulation 315.703a. **[396]**☐ 2. The employee named above does not meet the examination standards for conversion under CS Regulation 315.703a.		
Commission Office or Interagency Board of Examiners **[930]**	By **[58]**	Date **[483]**

TYPE OR PRINT THE NAME, ADDRESS AND ZIP CODE OF THE OFFICE REQUESTING THE ABOVE ACTION.

[14, 469]

CSC FORM 648 [146]
January 1968 [9]

DIGITAL OPF
OPF Document Sample with Data Elements

United States Civil Service Commission

Proof of Selection for Career (or Career-Conditional Appointment)

ABC Agency **[14]**
1234 Washington Street **[469]** Date: **[489]**
Washington, D. C. 23456 To: **[148]**

The United St ates Civil Service Commission hereby certifies that the person named below has been selected in regular order from a competitive register. Entry on duty and completion of probation under a career or career-conditional appointment as a result of this selection will confer competitive civil service status upon the person concerned.

NAME (First, middle, maiden, if any, last)			BIRTH DATE (Mo., day, year)
[77, 78, 79, 821, 162]			**[468]**
TITLE OF POSITION **[80]**	GRADE **[125, 127, 114]**	SALARY **[660, 823]**	CIVIL SERVICE CERTIFICATE NO. **[599]**
CERTIFYING OFFICE (Office, name, and address, including ZIP Code) U. S. Civil Service Commission **[18]** 5678 Washington Street **[472]** Washington, D. C. 23456			SIGNATURE OF AUTHORIZING OFFICER **[52]** OFFICIAL TITLE **[55]**

If the person covered by this selection enters on duty under this authority, file this form on the permanent (right)side of the employee's Official Personnel Folder.

AGENCY REPORT TO THE CIVIL SERVICE COMMISSION THAT ELIGIBLE SELECTED WAS NOT APPOINTED

If the person selected is not appointed, check the reason below, address to the authorizing office of the Commissioner, and return to that office for appropriate action. (Other notification of cancellation of this selection is not required.)

REASON FOR CANCELLATION: | CHECK ONE:

[600] ☐ DECLINATION
[1135] ☐ FAILURE TO REPLY
[1136] ☐ FAILURE TO REPORT
[1137] ☐ OTHER (Specify) **[931]**
[853] ☐ QUALIFICTIONS STATEMENT ATTACHED
[859] ☐ QUALIFICATIONS STATEMENT NOT ATTACHED (STATE REASON) **[935]**

[18]
[472]

CSC Form 2800-A [146]
September 1968 [9]

DIGITAL OPF
OPF Document Sample with Data Elements

United States Civil Service Commission
Authorization of and Proof of Selection for Career-Conditional Appointment)
(Plan C, Appendix E to Chapter 332 of the FPM)

ABC Agency **[14]**
1234 Washington Street **[469]** Date: **[489]**
Washington, D. C. 23456 To: **[148]**

The United States Civil Service Commission hereby authorizes the appointment of the person named below, subject to investigation and to the conditions stated below, if any. Entry on duty and completion of probation under a career-conditional appointment as a result of this authority will confer competitive civil service status upon the person concerned.

NAME (First, middle, maiden, if any, last) **[77, 78, 79, 821, 162]**			BIRTH DATE (Mo., day, year) **[468]**
TITLE OF POSITION **[80]**	GRADE **[125, 127, 114]**	SALARY **[660, 823]**	CIRCULAR NO.. **[599]**
CERTIFYING OFFICE (Office, name, and address, including ZIP Code) U. S. Civil Service Commission **[18]** 5678 Washington Street **[472]** Washington, D. C. 23456			SIGNATURE OF AUTHORIZING OFFICER **[52]** OFFICIAL TITLE **[55]**

ADDITIONAL CONDITIONS (if any) **[912]**

If the person covered by this selection enters on duty under this authority, file this form on the permanent (right)side of the employee's Official Personnel Folder.

AGENCY REPORT TO THE CIVIL SERVICE COMMISSION THAT ELIGIBLE SELECTED WAS NOT APPOINTED

If the person selected is not appointed, check the reason below, address to the appropriate monitoring office of the Commissioner, and return to that office for appropriate action.
REASON FOR CANCELLATION:

[600] ☐ DECLINATION **[1135]**☐ FAILURE TO REPLY **[1136]**☐ FAILURE TO REPORT

[1137] ☐ OTHER (Specify) **[931]**

[18,472]

CSC Form 2800-B [146]
December 1965 [9]

DIGITAL OPF
OPF Document Sample with Data Elements

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. Name (Last, First, Middle) [77, 78, 79, 821]	2. DEPARTMENT, COMPONENT AND BRANCH [15]	3. SOCIAL SECURITY NUMBER [880]

4.a. GRADE, RATE OR RANK [119]	4.b. PAY GRADE [120]	5. DATE OF BIRTH (YYMMDD) [468]	6. RESERVE OBLIG.TERM.DATE [209]		
			Year	Month	Day

7.a. PLACE OF ENTRY INTO ACTIVE DUTY [476]	7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address, if known) [1131]
8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND [20]	8.b. STATION WHERE SEPARATED [21]
9. COMMAND TO WHICH TRANSFERRED [19]	10. SGLI COVERAGE ☐ [1129] Amount: $ [663]

11. PRIMARY SPECIALITY (List number, title and years and months in speciality. List additional speciality numbers and titles involving periods of one or more years.) [978, 603, 688]	12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
	a. Date Entered AD This Period	[203]		
	b. Separation Date This Period	[204]		
	c. Net Active Service This Period	[790]	[788]	[789]
	d. Total Prior Active Service	[687]	[67]	[85]
	e. Total Prior Inactive Service	[689]	[101]	[102]
	f. Foreign Service	[685]	[86]	[99]
	g. Sea Service	[690]	[139]	[140]
	h. Effective Date of Pay Grade	[208]		

13 DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) [976]

14. MILITARY EDUCATION (Course Title, number of weeks, and month and year completed) [207, 686, 977]

15a. MEMBER CONTIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATION ASSISTANCE PROGRAM	Yes	No	15b. HIGH SCHOOL GRADUATE OR EQUILANT	Yes	No	16. Days Accured Leave Paid [683]
	[1130]	[1146]		[602]	[914]	

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION	[237]	Yes	[669]	No

18. REMARKS [931]

DD 214

DIGITAL OPF
OPF Document Sample with Data Elements

19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code **[135, 74, 75, 1, 73, 17]**	19.b. NEAREST RELATIVE (Name and address - include Zip Code) **[179, 475]**
20. MEMEBER REQUESTS COPY BE SENT TO **[607]** DIR OF VET AFFAIRS **[238]** Yes **[911]** No	22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and Signature) **[52, 54, 114, 55]**
21. SIGNATURE OF MEMBER BEING SEPARATED **[48]**	

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)		
23. TYPE OF SEPARATION **[979]**	24. CHARACTER OF SERVICE (Include upgrades) **[601]**	
25. SEPARATION AUTHORITY **[605]**	26. SEPARATION CODE **[606]**	27. REENTRY CODE **[604]**
28. NARRATIVE REASON FOR SEPARATION **[949]**		
29. DATES OF TIME LOST DURING THIS PERIOD **[594, 595]**	30. MEMBER REQUESTS COPY _______**[53]**______Initials	

DD 214 [146]
NOV 88 [9]

DIGITAL OPF
OPF Document Sample with Data Elements

Privacy Act
Accounting of Disclosure

Accounting of Disclosure (Privacy Act of 1974)	1. Name of Individual about whom material was disclosed **[77, 78, 79, 821]**	
	2. Date of Disclosure **[487]**	3. File Number **[1097]**
4. Description of Information Disclosed and Purpose of Disclosure **[980, 981]**		
5. To Whom Disclosed (Name & Address) **[148, 14, 479]**	6. Routine Use Description **[982]**	
7. List Privacy Act Provisions (Routine Use, Bureau of Census, Statistical Research, National Archives, Law Enforcement, Congress, GAO, Court Order, etc.) **[931]**		
8. Name of Person Making Disclosure **[52, 54]**	10. Personnel Office Identifier **[69]**	

DG 01
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

Birth Certificate

<table>
<tr><td rowspan="6">IMPORTANT DOCUMENT

This certification of birth card is valuable. Protect it.

Division of Vital Records [30]
P.O. Box 12345
Washington, D. C. [477, 478, 480, 481]

John Doe [148]
1234 Washington Street
Washington, D. C. 21234 [479]</td><td colspan="2">District of Columbia Department of Health
Division of Vital Records
CERTIFICATION OF BIRTH</td></tr>
<tr><td>Date Issued
[489]</td><td>File Number
[1097]</td></tr>
<tr><td colspan="2">Name
[77, 78, 79, 821]</td></tr>
<tr><td>Date of Birth
[468]</td><td>Sex
[955]</td></tr>
<tr><td>Place of Birth (County)
[3]</td><td>Date Filed
[488]</td></tr>
<tr><td colspan="2">This is a true certification of name and birth facts recorded in the Division of Vital Records - State Register of Vital Records
[52]</td></tr>
<tr><td>Mother's Maiden Surname: [165]
Father's Name: [164]</td><td colspan="2">LAMINATIONS, ALTERATIONS, ERASURES VOID THIS CERTIFICATE</td></tr>
</table>

Agency certification of Official Seal: **[186]**

DG 03
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[436, 636]

Certificate of Investigation

Date: ______**[489]**

Submitting Office: SON - **[112]** Security Office: SOI - **[68]**

Security Office
U.S. Office of Security ← **[631]**
1234 Washington Street, Room 1234
Washington, DC 23456

Name: **[77, 78, 79, 821]**

SSN: **[880]** DOB: **[468]** Position: **[80]**

Case Type: **[609]** Closing Date: **[211]** Opm Case #: **[1098]**
Scheduled Date: **[457]**

[1015]

This certifies that a background investigation on the person indentified above had been completed. The results of this investigation were sent to the Security Office for a security/suitability determination.

****

Agency certification: the results of this investigation have been reviewed, and a final determination has been made.

Agency Certifying Official Date
/s/ **[52]** **[490]**

- -

File this certificate on the permanent side of the person's official personnel folder after the final agency determination is made.

DG 04
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

Certified Copy of School Transcript

<table>
<tr><td colspan="3">Student Name
[77, 78, 79, 821]</td><td>STATE COLLEGE [176]
ABC City, XYZ State, 12345 [632]</td><td rowspan="3">Date Issued [489]

Official Seal [186]</td></tr>
<tr><td>Birthplace
[3]</td><td>Date of Birth [468]</td><td>Sex
[955]</td><td>DEGREE
DATE
[956] [692]</td></tr>
<tr><td colspan="3">Social Security Number
[880]</td><td>CREDENTIALS
[985]</td></tr>
</table>

Course Title	Term	Department Name	Course Number	Credits	Grade	Grade Points
[984]	[987]	[986]	[983]	[988]	[610]	[611]

DG 05
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[436, 636]

Requester ID: **[1099]**

Closed- Discontinued Notice
- -
Date: **[489]**

Security Office - SOI: **[68]** Submitting Office - SON: **[112]**

Office of Security
U.S. Office of Security ← **[631]**
Investigations Operations
Attention: John Doe
P.O. Box 1234
Washington, D.C. 23456

At the request of your agency, the office of security has discontinued the background investigation initiated on the following person:

Name: **[821, 78, 77, 79]**
SSN: **[880]** DOB: **[468]** Position: **[80]**

Case Type/service: **[609, 612]** Billing Rate: **[664]**
Scheduled Date: **[457]** OPM Case #: **[1098]**

[1099]

If there is any discrepancy between this information and your records, notify Office of Security immediately at (123) 456-7890. Please refer to the scheduled date and opm case number in any communications with OPM.

Remove the investigation scheduled notice from the temporary side of the person=s official personnel folder and place this notice on the permanent side.

DG 06
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[436, 636]

CLOSED INCOMPLETE NOTICE
DATE: **[489]**

Requester ID: **[1099]**

Security Office: SOI **[68]**

Submitting Office: SON **[112]**

Security Office
U.S. Office of Security **[631]**
Investigations Operations
Attention: John Doe

Department of ABC
[14, 469] P.O. Box 1234
Washington DC 23456-1234
Attention: John Smith

[1015]

OPM previously requested new finger print charts from the submitting office identified above in order to complete the background investigation initiated to the following person:

Name: **[77, 78, 79, 821]**

SSN: **[880]** DOB: **[468]** Position: **[80]**

To date we have not received the requested charts. Therefore, we are returning the attached papers and closing the case incomplete, to meet the investigative requirements of Executive Order 10405. You must submit new fingerprint charts.

Return this form and the attached papers and the charts.

Case Type/Service: **[609, 612]** Scheduled Date: **[457]** OPM Case #: **[1098]**

If the investigation is no longer required, remove the investigation schedule notice from the temporary side of the person's Official Personnel Folder, and place this notice on the permanent side.

DG 07
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

COMMONWEALTH OF *ABC*
DEPARTMENT FOR HEALTH SERVICES
REGISTRAR OF VITAL STATISTICS
Official Seal **[186]** CERTIFICATE OF DEATH **[30/480/481/477/478]**

The face of this Document has a colored background – NOT A WHITE BACKGROUND **[1097]**

Section	Field		
Decedent	1. Name (First, Middle, Last) **[42]**	2. Sex **[45]**	3. Date of Death **[693]**
	4. Social Security Number: **[44]**	5. Date of Birth **[71]**	
	6.Location of Death **[4]**	7. Marital Status **[957]**	8. Surviving Spouse **[166]**
Certifier	9a. Name & Signature of person who completed cause of death item **[52/54]**	9b. Date Signed **[490]**	
		10. Time of Death **[694]**	
Cause of Death	11. Describe condition of body and cause of death **[989]**	12. Manner of Death **[990]**	
		32. Date Filed **[488]**	

DG-08
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

OPM LETTERHEAD
[18, 472]

Date: **[489]**

Mr. John Doe **[148]**
Staff Director, Personnel **[16, 998, 619, 5, 625]**
ABC Agency
1234 Washington St.
Washington, DC 23456

[1015]

Dear Mr. Doe:

This refers to your request of August 5, 1992, for variation to permit the retention of John Smith **[77, 79, 78, 821]**, SSN: **[880]** in the position of Clerk-Typist (Part-time), GS-322-3, at the ABC Agency in Philadelphia, Pennsylvania.

To avoid hardship to the employee, the Director has approved your request effective October 6, 1992. The employee may be retained in his position and his service at the Personnel Support Center since May 24, 1992, may be credited for all purposes except for time-in-grade and career tenure. Credit for these purposes may be granted only from the effective date of this variation.

To document this variation in the Official Personnel Folder, follow the instructions in Subchapter 32 of the Guide to Processing Personnel Actions to complete the SF 50. File this letter on the right hand side of the OPF, along with the copy of any correction action.

By direction of the Director:

Sincerely,
/s/ **[58]**
June Jones **[158]**
Chief, Noncompetitive Staffing Branch [461]

DG 09
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

RETAIN ON THE TOP RIGHT-HAND SIDE OF THE EMPLOYEE'S OPF

INFORMATION TO OTHER AGENCIES HIRING ABC AGENCY EMPLOYEES

[1015]

1. The ABC Agency is conducting a Personnel Management Demonstration Project under legislative authority. The Demonstration Project involves white collar pay, performance, staffing, and classification systems which differ from other Federal Systems. Occupational series are grouped into career paths, and former grades are grouped into pay bands, as shown in the chart below. Employees do not receive within-grade increases or special salary rates. SES and ST-3104 employees are covered under the Project but are not covered for pay purposes. Federal Wage Schedule employees are not covered by the Project.

2. Gaining agencies must use the chart provided below and the following procedures to determine the equivalent GS grade of an ABC Agency employee. This is required when processing a personnel action to acquire, through transfer, promotion, change to lower grade, or reinstatement, a current or former ABC Agency employee covered by the Demonstration Project.

CAREER PATH	PAY BANDS					
Scientific & Engineering Pay Plan ZP**	I*	II*	III*	IV	V	SES
Scientific & Engineering Technician Pay Plan ZT**	I	II	III	IV	V	
Administrative Pay Plan ZA**	I	II	III	IV	V	SES
Support Pay	I	II	III	IV	V	

Plan ZS**															
Corresponding GS Grade SES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

*Career Path Definitions
*The maximum rate for a ABC Agency pay band corresponds to the highest OPM special rate for positions in that band; however, ABC Agency employees in special salary rate occupations do not receive OPM increases in the special salary rate.

(ZP) Scientific and Engineering: Professional technical positions in the physical, engineering, biological, mathematical, computer, and social sciences; and student positions for training in these disciplines.

(ZT) Scientific and Engineering Technician: nonprofessional technical positions that support scientific and engineering activities through the application of various skills and techniques in the electrical, mechanical, physical science, biology, mathematics, and computer fields; and student positions for training in these skills.

(ZA) Administrative: professional specialist positions in such administrative and managerial fields as finance, procurement, personnel, librarianship, public information, and program management and analysis; and student positions for training in these fields.

(ZS) Support: Positions that provide administrative support through the application of typing, clerical, secretarial, assistant, and similar knowledges and skills; positions that provide specialized facilities support, such as guard and firefighter; and student positions for training in these skills.

3. The equivalent GS grade of ABC Agency employees covered by the Demonstration Project will be one of the GS grades in the preceding pay band chart corresponding to the employee=s current pay band.

4. An employee in a pay band corresponding to a single GS grade will be converted to that grade, e.g., ZP-V = GS-15.

5. An employee in a pay band which corresponds to two or more GS grades is converted to

one of those grades according to the following procedures:

a. Using the non-special rate pay scale, the midpoint of GS pay levels is used to determine the appropriate grade. The midpoint is the dollar figure halfway between the minimum and maximum rates of the grade in the current GS pay schedule at the time of conversion to the General Schedule. To determine the midpoint of each grade in the pay band, subtract the salary corresponding to step 1 from the salary corresponding to step 10, divide by 2 and add this amount to the step 1 salary. This is your midpoint dollar figure for each grade.

b. The employee=s basic pay is compared to the midpoint dollar figure of each GS grade in the employee=s pay band to establish the grade with the midpoint that is closest, whether higher or lower, to the employees current basic pay.

c. In one-grade-interval grade ranges (ZS and ZT), the employee=s equivalent GS grade is the grade with the midpoint closest to the employee=s basic pay. In two-grade interval grade ranges (ZP and ZA), the employee=s equivalent GS grade is the appropriate grade for that series with a midpoint closest to the distant from the midpoints of two appropriate grades, the equivalent grade is the higher grade.

6. In spite of the guidance given above, in no circumstances would the conversion of an ABC Agency employee from a pay band to a GS equivalent grade result in an employee being placed in a grade lower than the grade which the employee held immediately prior to entering the Demonstration Project.

7. After arriving at the conversion grade, it is necessary to determine the conversion step of that grade.

a. The employee=s pay will determine the conversion step. If the employee=s pay is identical to the pay of a step in the conversion grade, than that step will be the conversion step. If the employee=s pay falls between two steps, the higher step is the conversion step.

b. If the employee=s pay falls above the 10th step of the conversion grade, the tenth step is the conversion step.

8. The date of last equivalent increase may be identified by using the most recent promotion or performance pay increase or this increase equaled 3 percent or more of the employee=s base pay, the effective date of the action is the date of last equivalent increase. If it was less than 3

percent of the employee=s base pay, a review must be made of prior personnel actions to identify the last date upon which the employee received a cumulative increase of at least 3 percent. For example, if an employee received a performance pay increase of 4 percent the effective date of the performance pay increase is the date of last equivalent increase. If the employee=s performance pay increase was 2 percent, a review of the official Personnel Folder (OPF) should be made to identify prior actions representing pay increases which, when combined with the 2 percent, add up to a 3 percent increase, or above, in base pay. The date on which cumulative actions reach or exceed 3 percent is the date of last equivalent increase.

9. Any questions concerning employees covered by the Demonstration Project should be referred to: ABC Agency, Office of Personnel, Administration Building, Rm. A-123, Washington D.C. **[16, 998, 619, 625, 5]**

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

Mr. John H. Doe **[77, 78, 79, 821]**
P.O. Box 1234 **[1, 73, 17, 74, 75]**
Washington, D. C. 21234

Date: **[489]**

RE: Doe v. Department of ABC
Docket No. SF-1234-5678-I-1 **[1097 or 1101]**
Date of Birth: **[468]**
SSN: **[880]**

[1015]

Dear Mr. Doe:

In accordance with the Administrative Judge's order in the above case, we have reviewed your service with the ABC Department for creditability under the special retirement provisions of 5 U.S.C. 8339 (c) for firefighters. In conducting our review, we are aware that you have not been able to contact a supervisor to obtain additional statements regarding your duties. Accordingly, we have relied on the evidence you submitted with your request for review.

Section 8336 (c) provides for retirement at age of 50 of an employee who was completed 20 years of service as a law enforcement officer or firefighter. A firefighter for purposes of section 8336 (c) is defined by Section 8331(21) as:

> ... an employee, the duties of whose position are primarily to perform work directly connected with the control and extinguishment of fires or the maintenance and use of firefighting apparatus and equipment, including an employee engaged in this activity who is transferred to a supervisory or administrative position.

Based on the documentation submitted we have determined that the following service meets the criteria under 5 U.S.C., Section 8336 (c) in the Primary category:

Position Title	Grade	Dates of Service
[80, 87]	**[124, 122]**	**[456, 458]**

Fire Control Aid	GS-5	06/65-10/65
Electronics Technician	GS-5	09/11/67 - 05/14/68
Electronics Technician	GS-5	05/15/68 - 08/09/69

If current position/grade were listed the codes would be: **[125, 114]**

We have reviewed the material submitted and have concluded that the documentation presented for the following service does not show that you have satisfied the definition of firefighter under current law and regulation. We have not allowed the credit due to insufficient evidence to determine that your primary duties were those of firefighting. Duties that are emergency, incidental or temporary in nature cannot be considered "primary" even if they meet the substantial portion of the time criterion.

Position Title	Grade	Dates of Service
[80, 87]	**[124, 122]**	**[456, 458]**
Primary Aid	GS-3	06/62 - 09/62
Primary Aid	GS-4	09/62 - 10/62
Primary Aid	GS-4	09/63 - 01/64

If current position/grade were listed the codes would be: **[125, 114]**

In most cases, we require position descriptions, or if unavailable or not reflective of the actual duties performed by the employee, affidavits supporting the claim for coverage. In your case, you state that you were unable to locate your supervisor. Therefore, we based our determination on the information contained on the SF-171, which you submitted as part of your formal request. Based on that document and the information it contains, for the periods June 1962 - January 1963, June 1963 - January 1964, and June 1964 - November 1964, you stated that your duties consisted of primarily thinning, mapping, marking, and spraying for insects, etc., work that has no firefighting associated with it. If we apply the criteria set forth above, even though you mention that your duties for the period June 1964 - November 1964 included being ready for immediate dispatch to fires, it does not appear, in our judgment, that your primary duties were to fight fire. Rather that was an emergency, incidental or temporary type of duty. Therefore, we have denied any credit under 5 U. S. C. 8335 (c) for the above periods of service.

If any of the above service was in a position that was not approved for general

coverage under 8336 (c), the full 7.5 percent retirement contribution may not have been withheld. In accordance with Public Law 93-350, your agency must now collect the additional .5 percent. In accordance with 5 CFR 831.911(b), this payment must be made to OPM within 30 days of the date of this letter.

With regard to your service as an Electronics Technician, GS-856-11, from November 15, 1981 to the present, we have deferred any decision on that service. Because you have occupied that particular position continuously since November 15, 1981, it is considered to be your current official position. In the case of current official position descriptions, the process of preparing, certifying and regularly re-certifying the accuracy of the current position descriptions is intended to affirm their accuracy. Your current position description does not illustrate the primary duty of direct involvement in extinguishing fires or the maintenance and use of firefighting equipment that is necessary to meet the definition of covered work in 5 CFR 831.901.

We recognize that you may believe your official position description to be inaccurate, and recommend that you discuss this matter with your immediate supervisor, who is responsible for its accuracy for purposes of pay, performance and other matters as well as retirement coverage. If a change of duties or classification is called for, your servicing personnel office understands the procedures to document the changes and submit the position description for a ruling on the firefighter retirement coverage, if appropriate.

We have informed the Department of ABC of our determination. A copy of this letter should be attached to your retirement application when it is forwarded to OPM. If you have any questions please contact Ms. Jane T. Smith **[149]** on (202) 123-4567 **[106]**.

Sincerely,
/s/ **[52]**
John J. Smith **[54]**
Director of Personnel **[55]**

cc
Merit Systems Protection Board **[437]**
123 Washington St.
Washington D. C. 21234 **[635]**

MEMORANDUM OF UNDERSTANDING
GOVERNING THE ASSIGNMENT OF DETAILED INSTRUCTORS

BETWEEN THE

NAME OF AGENCY **[22]**
AND
THE ABC AGENCY **[23]**

Employee Name **[77, 78, 79, 821]**
Employee SSN **[880]**

[1015]

INTRODUCTION

The ABC AGENCY (hereinafter referred to as the Center or ABC AGENCY), in partnership with the participating organizations, provides high quality law enforcement training to law enforcement personnel.

Because a meaningful training program is dependent upon the talents of the instructional staff, it is vital that instructors be highly qualified and dedicated, trainers. To ensure the quality of the instructional staff and training, the ABC AGENCY and the (NAME OF AGENCY) agree to the principles contained herein governing the assignment of detailed instructors to the Center, as adopted by the ABC AGENCY=s Board of Directors on July 25, 1995.

SUPERVISORY/MANAGEMENT PRINCIPLES

1. ASSIGNMENT OF RESPONSIBILITIES - Recognizing the importance of making the detail assignment mutually beneficial to the ABC AGENCY, the XXXXXX, and the individual instructors assigned, pre-recruitment/selection conferences will be held between the ABC AGENCY and the XXXXXX. The purposes of these conferences will be to discuss areas of need and interest and agree upon the primary training division of assignment for the detailed instructor. Because the workload of the ABC AGENCY training divisions varies throughout the year, work assignments outside the assigned training division may occur from time to time. However, detailed instructors will not be placed in another training division for more than 60

days nor be reassigned permanently to a different training division without the concurrence of the XXXXXX. Furthermore, such adjustments will be made only when it is essential to meet the instructional workload or it is mutually agreed to be in the best interest of the XXXXXX and the ABC AGENCY.

2. WORK ASSIGNMENT- Instructors detailed by the XXXXXX will receive supervision and administrative orders from their authority to adjust the work assignment and hours of the detailed instructors. Every effort will be made to ensure equity between those assigned, whether agency detailed instructor or permanent ABC AGENCY staff. When required, overtime will be paid in accordance with and at rates applicable under law.

3. EVALUATION - All detailed instructors will receive an annual performance evaluation from their ABC AGENCY division supervisor. The ABC AGENCY performance evaluation will be provided to the detailed instructor=s XXXXXX supervisor, who will incorporate that rating into the detailed instructor=s formal performance rating. ABC AGENCY supervisors are obligated to inform the detailed instructors= XXXXXX supervisor as concerns develop with the performance of the instructor and not delay notification until the end of the review period. In those cases involving a failure to meet established ABC AGENCY performance standards, either the ABC AGENCY or the XXXXXX may terminate the detail after consultation with each other.

4. DISCIPLINE - The last resort of a supervisor in the pursuit of compliance with policies, rules, and regulations, is disciplinary action. Because it is the XXXXXX=s prerogative to administer discipline in those cases which warrant such action, no attempt is made to usurp that authority. However, disciplinary action is also a supervisory function. The assigned contemplated MISSING SENTENCE when that decision is the result of an action or inaction involving the ABC AGENCY or its progress and policies. After conferring with each other, on cases involving a breach of policies, rules, or regulations reflecting negatively upon the ABC AGENCY, either the ABC AGENCY or the XXXXXX may terminate the detail.

5. LEAVE - Time and attendance records of detailed XXXXXX personnel will be maintained by the XXXXXX. Instructors detailed to the Center will request all leave using a SF-71, a copy of which will be provided to the XXXXXX. The immediate ABC AGENCY supervisor has final approval authority for leave and will make reasonable efforts to adjust work schedules so that non-emergency leave can be granted as requested; however, in some cases it may be necessary to deny some requests.

ADMINISTRATIVE/MANAGEMENT PRINCIPLES
6. INSTRUCTOR EDUCATION/EXPERIENCE REQUIREMENTS - It is the intent of the ABC AGENCY and the XXXXXX to provide the best qualified instructors. With this in mind, the ideal detailed instructor candidate will possess a four year college degree, have teaching or training experience, and minimum of five years of progressively responsible law enforcement experience. Lesser levels of formal education and a lack of teaching experience will be acceptable when there are significant levels of practical experience in the law enforcement field to demonstrate significant credibility as a subject matter expert. The ABC AGENCY knowledge, skills, abilities, and other characteristics (KSAO=s) for the position (s) under consideration will be shared with the XXXXXX and will be given due consideration during the selection process.

7. SELECTION PROCESS - The XXXXXX will narrow its list of interested personnel to at least three and submit those names and SF-171=s (or an equivalent record of work history) to the ABC AGENCY supervisor of the office to which the detailed instructor is to be assigned, indicating a preference as to the individual to be selected. After review of the SF-171=s (or equivalent) and interviews if desired by the ABC AGENCY supervisor, a joint selection decision will be made.

8. MOVING EXPENSES - The ABC AGENCY agrees to pay reasonable personnel relocation expenses associated with the detailed instructor=s transfer to the ABC AGENCY, including subsistence expenses while occupying temporary quarters for a period of not more than 60 consecutive days. The ABC AGENCY will not, as a matter of routine, include a residence buy-back provision. The XXXXXX will accept all costs associated with the return of the detailed instructor to the XXXXXX.

9. ASSIGNMENT DURATION - The XXXXXX agrees to a three year tour of duty for all detailed instructors and limited extensions of up to two years with the concurrence of the XXXXXX and the ABC AGENCY.

10. REPLACEMENT PROCEDURES - Every reasonable effort will be made for replacement instructors to report 30 days prior to the departure of their predecessors. This provides the new detailed instructor the opportunity for discussions with the departing detailed instructor on issues, concerns, etc., which will impact the individual=s performance and expedite the overall orientation. This overlap will ensure smooth transition and allow for continuity of XXXXXX representation in the instructor ranks

11. SPECIAL ASSIGNMENTS/PROJECTS - Additional work requirements placed on the detailed instructor by the XXXXXX will be submitted to the ABC AGENCY supervisor, for review and approval, well in advance of the need.

/s/ **[52]**	**[490]**	/s/ **[59]**	**[492]**
Name **[54]**	Date	John J. Doe **[571]**	Date
Title **[55]**		Deputy Director **[12]**	
Agency **[22]**		ABC AGENCY **[23]**	
		Training Center	

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

Employee's written Agreement to Accept Voluntarily the conditions attendant to a change from career to noncareer or limited SES appointment

Date: **[489]**

Employee Name: **[77, 78, 79, 821]**
SSN: **[880]**

[1015]
↕
Dear _____________

I voluntarily accept the conditions to change from a career position as a __**[959]**______ to a ___________ (Noncareer/ limited/SES) appointment to the position of ___________. I understand the conditions of the new appointment and that my retirement coverage will change to **[944]**. This will be effective on **[212]**.

Sincerely
/s/
[48]
Date signed: **[219]**

DG 14
[146]

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PERSONNEL ACTION LISTING [931]
(SF 50 EXCEPTION)

Nature of Action Code and Action: **[806, 934]**
Effective Date: **[212]**
Authority Code and Authority: **[798, 940]**

FROM:	Hearings Bureau **[32]** KLM Agency Washington, D.C. **[41]**
TO:	ABC Agency **[16]** Washington, D.C. **[25]**

Name	Social Security No.	Birth Date
[77, 78, 79, 8321]	**[880]**	**[468]**

FROM:	TO:
Agency Code **[173]**	Agency Code **[629]**
POI **[172]**	POI **[469]**

Date: **[490]**

/s/ **[52]**
John Jones **[54]**
Personnel Officer **[55]**

Second Approval: **[571, 59, 12]**

Type of appointment, position, grade and salary remain unchanged. [942]

DG 17
[146]

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PERFORMANCE APPRAISAL

PART I – ADMINISTRATIVE DATA

a. NAME (Last, First, M.I.)	b. SSN	C. POSITION TITLE & NUMBER, PAY PLAN, SERIES & GRADE
[77, 78, 79, 821]	**[880]**	**[80, 125, 127, 114]**

d. ORGANIZATION	e. PERIOD COVERED (YY/MM/DD)
[16, 25]	**[215, 216]**

PART II - AUTHENTICATION

a. NAME OF RATER (Last, First, M.I.)	SIGNATURE	DATE
[577]	**[142]**	**[494/43]***
GRADE/RANK, ORGANIZATION, DUTY ASSIGNMENT **[369]**		
b. NAME OF INTERMEDIATE RATER (Last, First, M.I.) (Optional)	SIGNATURE	DATE
[151]	**[184]**	**[185]**
GRADE/RANK, ORGANIZATION, DUTY ASSIGNMENT **[402]**		
b. NAME OF SENIOR RATER (Last, First, M.I.)	SIGNATURE	DATE
[578]	**[143]**	**[495]**
GRADE/RANK, ORGANIZATION, DUTY ASSIGNMENT **[402]**		
d. RATEE I understand my signature does not constitute agreement or disagreement with the evaluation of the Rater and Senior Rater and merely verifies Part I and Part IV data.	SIGNATURE OF RATEE **[48/161]***	DATE **[219/506]***

PART III – PERFORMANCE AWARD/QUALITY STEP INCREASE

a. RECOMMENDATIONS

[1015]

PART IV – DUTY DESCRIPTION (Rater)

[1015]

Overall Rating
[613] Rating code
[361] Rating

*Additional elements mapped to accommodate data included by other agencies

DG-19
[146]

DIGITAL OPF
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OPM LETTERHEAD
[18, 472]

Department of ABC **[16]**
Office of Human Resources
& Mgmt Services **[998, 619, 5, 625, 135]**
1234 Washington Street, Room 123
Washington, D. C. 23456

CSA: **[1101]**
SSN: **[880]**
RE: **[77, 78, 79, 821]**
DATE: **[489]**

[1015]

Dear Personnel Officer:

We have approved the application for Disability Retirement for the individual MISSING WORDS of the approval and advising him or her that we are asking for information from you that will help us establish monthly interim payments and complete final adjudication of the annuity.

The records sent us to date show that the individual has not been separated. Since it is possible that pay may have stopped and the individual is without income, we need to know immediately the last day of pay. This will allow us to begin sending monthly interim annuity payments to the (former) employee within a short period of time.

To expedite the processing of the annuity, please call a representative at our Boyers office with the last day of pay as soon as possible after you receive this letter on (412) 123-4567. Or if you prefer you may send them the last day of pay informtion by FAX (412) 765-4321. If you are sending a FAX, please also FAX a copy of this letter with your response. If the last day of pay will occur in the future, please mark the employee=s record so that the last day of pay, when established, will immediately be sent to us.

In addition, we are asking you to submit final retirement records through the regular retirement processing channels of your agency. Final records are necessary before we can complete final adjudication of the annuity.

We believe it is vitally important that we meet the needs of our customers; your employees, and you, the agency. We are working to respond to these needs by processing disability retirement applications as quickly as possible. You can help us respond effectively by giving us the last day of pay immediately (or as soon as the employee is separated), and by processing retirement

records quickly through your agency and to our Retirement Operations Center in Boyers, Pennsylvania.

Thank you for your help.

Sincerely,

/s/
[58]
John Doe **[158]**
Benefits Specialist **[461]**
Claims Branch **[462]**
Disability Entitlements Division

Attachment (Approval Checklist)

cc:

[77, 78, 79, 821] Employee name
[1, 74, 75, 73, 17] Employee address

DIGITAL OPF
OPF Document Sample with Data Elements

[1015]

Forward a copy of this notice, along with all required documentation to:

Federal Employees Retirement System
Retirement Operations Center
Boyers, PA 16017
or
Civil Service Retirement System
Retirement Operations Center
Boyers, PA 16017

Check off the items you are sending to OPM.

[244] All SF 2809=s in the applicant=s OPF.
[245] SF 2810 transferring the Health benefits enrollment to the Retirement System
[243] All other SF 2810=s in the applicant=s OPF
[240] SF 2821 and SF 2818
[241] All SF 54=s and SF 2823=s in the applicant=s OPF
[242] All SF 2817=s
[246] All SF 3102=s
[247] SF 2806, SF 3100, or SF 3100A.
[254] SF 2807 or SF 3103
[252] OWCP award, if applicable. Under ARemarks@ please show the OWCP claim number and the date OWCP benefits began.
[251] Remarks/Other documents submitted (please specify - **[931]**)

Please furnish the information requested below if the SF 2806 or SF 3100 and other document cannot be submitted within 10 working days.

[249] Employee is on leave without pay. Last day of pay was **[699]** .
[250] Employee is on leave without pay because of OWCP benefits.
[253] Final SF 2806 or SF 3100 cannot be forwarded now because employee is still in a pay status. (Last day of pay will be **[700]**)

If the SF 2806 or SF 3100 and other documents have already been submitted to OPM, please furnish the information requested below.

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OPF Document Sample with Data Elements

[248] Final SF 2806 or SF 3100 was forwarded to OPM on Register # **[1097]**, dated **[496]**.

/s/
[52]
Date **[490]**
Phone number **[108]**
Fax number: **[463]**

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

Date: **[489]**
Employee Name: **[77, 78, 79, 821]**
SSN: **[880]**
Employee Address: **[74, 1, 17, 75, 73]**

[1015]

Your coverage in the Federal Employees Health Benefits Program (FEHB) ends on the last day of the pay period in which you separate from Federal service, subject to a 31- day temporary extension of coverage (at no cost to you) for conversion to a nongroup contract.

You also have the right to temporarily continue your FEHB coverage for up to 18 months after your separation instead of converting to a nongroup contract at this time. You may select any plan in the FEHB Program in which to continue your coverage, you must pay the full amount of the premium (both the employee and Government shares) plus a 2 percent administrative charge. If you choose to continue your coverage, during the first 31 days, you have the free coverage described above. Your enrollment charges begin on the day after the 31-day period of free coverage ends. If you continue the coverage to the end of the 18-month period, you will have another 31-day temporary extension of coverage for conversion to a nongroup contract.

If you are interested in continuing your FEHB coverage, you must complete the enclosed registration form and return it to the following address:

ABC AGENCY
1234 Washington Street, Room 1234
Washington, D. C. 23456
Attn: John Doe

If you choose to continue your coverage, please submit your registration form to the address shown above within 60 days after the date of your separation, or the date you receive this notice, whichever is later.

Sincerely,

/s/ **[52]**
John Smith **[54]**
Office of Human Resources **[55]**

DG 21
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 470]

Employee: **[77, 78, 79, 821]** Date: **[490]**
SSN: **[880]**

[1015]

Dear Employee,

This serves to advise you of changes which will impact your future rights and benefits as a Federal Employee. Please review the following and contact Ms. Smith, Staffing Office (202) 123-4567 if you have questions or believe this information to be incorrect.

You were on a "Leave Without Pay" status during the period April 01, 1996 through April 22, 1997. We have adjusted your SCD to compensate for the period of leave without pay which exceeded regulatory limitations. Your new SCD for leave purposes is July 8, 1987. The proposed date for your next within grade increase has been adjusted to September 8, 1999. You will receive the increase effective the pay period following that date provided you meet all legal and regulatory requirements for the increase at that time.

We are happy to have you back as a member of the active work force.

Sincerely,

/s/ **[52]**
John Doe **[54]**
Chief, Operations Branch **[55]**
Human Resources Office

DG 22
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[28, 6, 135]

DESCRIPTION OF PEACE CORPS/VISTA/ACTION VOLUNTEER SERVICE

[1015]

Person **[77, 78, 79, 821]** entered training on date **[217]** at Monitor Training Center in Aregua, Paraguay and completed an intensive twelve week program. Included in the subjects studied were cooperative accounting, financial statement analysis, cooperative management, agricultural production (in general), pesticide management, inventory control, auditing, Spanish language and cultural adaptation. He was enrolled in the Peace Corps/Vista/Action on date **[213]**.

__________ was responsible to CREDICOOP, the National Federation of Cooperatives of Paraguay, during his three year service in Paraguay. He served as marketing advisor assigned to Credicorp Marketing Department. As a Peace Corps/Vista/Action Volunteer and marketing advisor, he has worked in the following areas:

-- inventory control/demand forecasts of farm supplies available to ag-coops
-- study on tomato production cost (USAID/CREDICOOP Crop Intensification Project)
-- study of cotton transportation costs; related to cost/benefit study of CREDICOOP cotton gin operation;
-- implementation of cotton-price information program utilizing New York Cotton Exchange daily quotes of cotton commodity future contracts; information supplies via telex to CREDICOOP by subsidiary of Shearson/American Express and used as basis for price forecasting model in CREDICOOP=s cotton exportation operation;
-- technical advisor and collaborator to USAID financed contract consultants (MAS in relation to USAID/CREDICOOP Crop Intensification Project;
-- collaborator on various USAID/CREDICOOP Minifundia Crop Intensification Project Quarterly Progress Reports;
-- established and implemented a food marketing research program in the Marketing Wholesale Produce Market of Asuncion (Mercado de Abasto) on daily prices and monthly volumes of the principle products marketed there;
-- assisted a Volunteer from the Volunteer Development Corps in working with CREDICOOP management on cotton gin management/administration cotton marketing;
-- researched and wrote project proposal for an Apple Computer Inc. contribution a microcomputer network to CREDICOOP;

-- attended a Linear Programming seminar sponsored by IICA (Inter American Institute for Cooperation in Agriculture) to officials from USAID, Ministry of Agriculture CREDICOOP and private industry; worked on revising LP model of the USAID/CREDICOOP Minifundia project;
-- assisted Dr. John Doe, USAID-financed consultant from the University of XXX in background marketing work related to the redesign of the USAID/CREDICOOP Minifundia Crop Intensification Project;

-- collaborated in various Volunteer training programs with respect to food marketing and product preparation/packaging for the market.

Additionally, __________ traveled through Argentina, Bolivia, and Brazil; he is married to a Paraguayan,

Pursuant to section 5 (f) of the Peace Corps Act, 22 U.S.C. #2504 (f) as amended, any former Volunteer employed by the United States Government following his Peace Corps Volunteer service is entitled to have any period of satisfactory Peace Corps Volunteer service credited for purposes of retirement, seniority, reduction in force leave and other privileges based on length of Government service. Peace Corps service shall not be credited toward completion of the probationary or trial period or completion of any service requirement for career appointment.

This is to certify in accordance with Executive Order No. 11103 of April 10, 1963, that Mr. ____________ served satisfactorily as a Peace Corps/Vista/Action Volunteer. His service ended on December 10, 1983 [210]. He is therefore eligible to be appointed as career conditional employee in the competitive civil service on a non-competitive civil service on a non-competitive basis. This benefit under the Executive Order entitlement extends for a period of one year, except that the employing agency may extend the period for up to three years for a former Volunteer who enters military service, pursues studies at a recognized institution of higher learning or engages in other activities which in the view of the appointing authority warrants extension of the period.

Date: **[490]**

/s/ **[52]**
Director **[55]**

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

MEMORANDUM FOR EMPLOYEE **[77, 78, 79, 821]** DATE: **[489]**
SSN: **[880]**

[1015]

SUBJECT: Termination of PMRS

The Performance Management and Recognition System (PMRS) sunsets on October 31, 1993. Section 4 of Public Law 103-89, the PMRS Termination Act of 1993, provided for the transition of former PMRS employees into their agency Performance Management System (PMS) and the General Schedule (GS) pay plan. This memorandum is your official notification of the expiration of the PMRS and your placement in the PMS and the GS pay plan. A copy of this memo will be placed in your Official Personnel Folder (OPF).

Effective November 1, 1993, **[212]** you will continue to be paid at your current rate of pay, as adjusted by any final merit increase, even if that rate is not a designated GS step rate. To help ensure accurate pay administration, agencies will continue to use the pay plan code "GM" (which OPM has redefined to designate GS employee covered by P.L. 103-89) along with the A00" step indicator. You will also become eligible for within-grade increases (WGIs) whenever you complete the applicable requirements. Your last merit increase will be your last equivalent increase for the purpose of beginning your WGI waiting period.

This transition will not require a change in your FY 94 performance plan even though you are now covered by the performance appraisal system that applies to other General Schedule employees. If you have any questions about your performance plan, please contact your supervisor.

/s/ **[52]**
Human Resources Officer **[55]**

DG 25
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

MEMORANDUM FOR EMPLOYEE **[77, 78, 79, 821]** DATE: **[490]**
SSN: **[880]**

[1015]
↕
SUBJECT: Career Tenure

You have been accorded Career Tenure as provided by the Code of Federal Regulations, 5 CFR 315.201(c)(1). This regulation states that you are excepted from the requirement to complete three years of continuous service to acquire tenure because you have been appointed to a position paid under Chapter 45, Title 39 of the United States Code.

A copy of this notification will be placed in your Official Personnel Folder. If you have questions regarding this issue, please contact Mr. John Doe at (202) 123-4567.

Sincerely,

/s/ **[52]**
Human Resources Officer **[55]**

DG 26
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

RECONSTRUCTED OPF NOTICE

TRANSCRIPT OF SERVICE

EMPLOYEE NAME**[821, 77, 78,** 79] DATE: **[489]**
SSN: **[880]**

[1015]

SUBJECT: Loss of Official Personnel Folder

Through no fault of his/her own, (name of employee) Official Personnel Folder was lost or destroyed. He/She was assigned to the positions listed below and/or employed as described below for the periods indicated.

Nature of Action	Position(title, series, grade & PD#)	Effective Date
101 Career Conditional App	Secretary GS-0318-5 step 1 560001	01-10-88
702 Promotion	Computer Clerk GS-0344-06 step 1 7200001	01-09-89

/s /**[52]**
John Doe **[54]**
Human Resources Office **[55]** r

This document is to be filed permanently on the right side of the employee=s Official Personnel Folder.

DG 27
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[436, 636]

Returned - Requirements Met Notice (Processed)

Date: **[489]**

Security Office : **[68]** Submitting Office :**[112]**

ATTN: Security Room M-123
ABC Agency ← **[14]**
1234 Washington Street
Washington, D. C. 2345 6 ← **[469]**

NAME: **[77, 78, 79, 821]**
SSN: **[880]** DOB:**[468]** POSITION : **[80]**

[1015]

OPM received the attached papers from the submitting office identified above. An investigation that meets or exceeds the same requirements as the type of case requested was completed within the past year. Therefore, no new investigation is required and we are returning the papers without inititiating one. The previous investigation was processed under Section 3(a) of Executive Order 10450. OPM determined that the investigative information compiled on this person was acceptable.

Relevant case information follows:

Case Type/serv :**[609]** / **[612]** Closing Date : **[211]** Opm Case # : **[1098]**

DG 28
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

Resignation Documents (Other than SF 52)

Date: **[489]**

ABC Agency **[16]**

Dear ___**[29]**_____* (If received by phone **[149, 90]**)

[949]
↕
I, **[77, 78, 79, 821]**, hereby resign from my position as Data Transcriber effective: Thursday, May 2, 1996 **[212]**, due to health considerations. I apologize for being unable to give notice. Thank you for the opportunity of employment with the ABC Agency.

Very truly yours,

/s/ **[48]**
Date signed: **[219]**

* If supervisor name and title provided, substitute **[72, 91]** for **[29]**

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

1989 COMPARABILITY INCREASE

[931]

Dear Employee:

President Reagan has signed an Executive Order authorizing a 4.1 percent cost of living increase for all GS and GM employees who are not currently receiving the benefit of pay retention.

Your pay increase will be reflected in the salary check you receive on January 23, 1989. If the following information is incorrect, or if your increase is not reflected in your check at the appropriate time, or if you have any questions about how your increase was computed, please contact your servicing personnel office.

Employee name: **[77, 78, 79, 821]**
SSN: **[880]**
Pay Plan: **[125]** Grade: **[114]** Step: **[128]**
Salary: **[660, 666, 668]**
Effective date of increase: **[212]**
Authority for change and date of authority: **[940]**
Agency code: **[629]**
POI: **[69]**

DG 31
[146]

AGENC Y [16]
SENIOR EXECUTIVE PERFORMANCE AGREEMENT

EMPLOYEE'S NAME	SSN	RATING PERIOD
[77/78/79/821]	**[880]**	**[215/216]**

POSITION	BUREAU/OFFICE
[80]	**[25]**
DUTY LOCATION	ES LEVEL
[938]	**[114/127/125]**

Performance Element 1: *Continue Reinvention Activities*

Fully Successful Standard:

Performance Element 2: *Resources Management*

Fully Successful Standard:

Performance Element 3: *Human Resources/Diversity*

Fully Successful Standard:

Certification: Employee's signature certifies review and discussion of performance agreement with Rating Official. It does not mean that the employee concurs with the Performance Elements or Standards.

[48]	**[506]**	**[142/577/369]**	**[494]**
Employees Signature	Date	Rating Official Signature/Title	Date

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

DATE: **[489]**

MEMORANDUM FOR **[77, 78, 79, 821]**

FROM: Director, Office of Administration

SUBJECT: Specific Notice of Reduction in Force

[1015]

The ABC Bureau had been designated for elimination under the Department of the ABC Fiscal Year 1996 Appropriation Bill agreed to by the House/Senate Conference Committee. The Bureau=s elimination is also supported by the Administration. Based on this information, it is a reasonable expectation that the language contained in the Appropriation Bill will be enacted into law in the near future. Certain activities have been identified by Congress for transfer to other ABC bureaus and to a different Department. All other Bureau activities and locations not specifically identified are to be closed. This elimination of the ABC Bureau requires the use of Reduction in Force (RIF) procedures.

This is your specific notice of how you will be affected by the RIF described in the first paragraph. We regret to inform you that you have been identified for separation, because your activity is not one slated for transfer to other ABC Bureaus or to a different Department.

Management has identified your position as one needed for liquidation; your separation will be effective on March 8, 1996 **[212]**.

Information concerning your RIF retention standing is as follows:

Competitive Area:	Headquarters positions within the Washington DC metropolitan area **[1020]**
Present Position:	Personnel Management Specialist, GS-201-11 **[80, 125, 127, 114]**
Competitive Level:	**[614]**
Tenure Group and Subgroup:	**[811, 616]**
Type of service:	Competitive **[575]**

SCD: **[706]**

Last Four Performance Ratings:

Year	Rating
[705]	**[613]**
[702]	**[828]**
[703]	**[827]**
[704]	**[829]**

Adjusted SCD Using Last Three Performance Ratings: **[701]**

[1015]

Based on this specific notice, you are eligible for severance pay. You are also eligible for the Department of the ABC Reemployment Priority List (RPL) and the Office of Personnel Management Interagency Placement Program (IPP). General information about the RPL, the IPP and other benefits available as a result of a RIF action is contained in the attached Reduction in Force Benefits Guide. Also attached is information concerning applying for unemployment benefits in Washington, D.C. Please contact the Division of Personnel on 123-4567 for additional information or clarification of these benefits.

This RIF is being processed in accordance with the Liquidation Provisions of the RIF regulations contained in Part 351 of Title 5, Code of Federal Regulations (CFR), Section 351.605, and ABC Manual Chapter 370 DM 351 and as modified by the Appropriation Bill. These procedures provide for the separation of employees without regard to retention standing within the subgroup. The date of final liquidation within your competitive area is March 31, 1996. This information and all records pertaining to your RIF action, including retention registers, are available for your review. You may schedule an appointment to see this information and discuss the action planned in your case by calling Ms. Jane Doe or Mr. John Smith **[149]** Division of Personnel Branch of Employment and Employee Development **[29]** on 987-6543 **[106]**.

You may appeal this action to the Merit System Protection Board (MSPB) **[437],** Washington Regional Office, 1234 Washington Street, Room 5555, Washington, D. C. 23456-7890 **[635]**. Your appeal must be in writing and must be made during the 30-day period beginning on the day after the effective date of this action. An appeal form is attached to this memorandum. A

copy of the MSPB regulations may be obtained from the Division of Personnel. In accordance with 5 CFR 1201.22 (c), if you do not appeal within the 30-day time limit, your appeal will be dismissed as untimely filed unless a good reason for the delay is shown. The judge will provide you an opportunity to show why the appeal should not be dismissed as untimely.

If you choose to resign before being separated by RIF, your resignation will be considered an involuntary separation for purposes of entitlement to severance pay, if applicable; however, you will likely forfeit your rights to appeal to the MSPB and may lose eligibility for placement benefits under OPM's Interagency Placement Program and the ABC Reemployment Priority List.

This RIF does not reflect on your service or conduct. The first paragraph states the sole reason for this action. You may use this notice as a reference if you seek other employment.

We deeply regret the necessity for this action.

/s/ **[52]**
John Doe **[54]**
Chief, Affirmative Employment Branch **[55]**

Attachments:
RIF Benefits Guide
D. C. Unemployment Information
MSPB Appeal Form

Receipt Acknowledged:

_/s/_**[48]**_________________________ _____**[219]**__________
Employee Signature Date

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

Statement of acceptance or declination of conversion to an SES Position

Date: **[489]**

Employee name **[77, 78, 79, 821]**
SSN: **[880]**

[1015]
↕
Dear___________________________

I accept/decline the conversion to the Senior Executive Service (SES) position of on date. I will enter the SES as a level ES-___ with a salary of ____-per annum. I understand that I will be required to serve a one year SES probationary period.

Sincerely,

/s/ **[48]**

Date: **[219]**

DG-36
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625, 135]

Statement of SES Career Appointee

Date: **[489]**

Employee Name: **[77, 78, 79, 821]**
SSN: **[880]**

[1015]

Dear________________________

I elect to continue under the provision of the Senior Executive Service (SES) for the position of __________, as a level ES-____ with a salary of _____ per annum, upon receiving the appointment by the President which was confirmed by the Senate. I want to retain all of the following SES benefits: basic pay, performance awards, rank awards, severance pay, annual and sick leave. I am scheduled to begin on date. I acknowledge that I must serve a one-year SES probationary period.

Sincerely,

/s/ **[48]**
Date **[219]**

DG-37
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

STATEMENT OF UNDERSTANDING

Date: **[489]**

[1015]

I, _________ **[77, 78, 79, 821]** SSN: **[880]** voluntarily leave my position in the competitive service to accept an appointment as a _____________in the excepted service.

The Civilian Personnel Office explained the difference between the excepted service appointment and competitive appointments to me before I accepted the excepted service position. I understand the distinctions between these types of appointments and the impact upon my benefits and entitlements.

/s/ **[48]**_______________ (Signature)

[219]_________________ (Date)

DIGITAL OPF
OPF Document Sample with Data Elements

DEPARTMENT OF VETERAN AFFAIRS LETTERHEAD
[436, 636]

DATE: **[489]**

Employee: **[77, 78, 79, 821]**
Address: **[74, 75, 1, 73, 17, 135]**

[1015]
↕
Dear_____________:

The following certificate is furnished for your use in establishing Civil Service preference.

This is to certify that the records of the Veterans Administration disclose that _____ is in receipt of disability compensation on account of service connected disability rated at 30 percent **__[1023]** or more. This payment is made in accordance with public laws administered by the Veterans Administration.

Sincerely yours,

/s/ **[49]**
John Doe **[167]**
Veterans Services Officer **[92]**

DG 40
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 619, 5, 625]

ETHICS PLEDGE

Employee Name: **[77, 78, 79, 821]**
SSN: **[880]**

[1015]

As a condition, and in consideration, of my employment in the United States Government in a senior appointee position invested with the public trust, I commit myself to the following obligations, which I understand are binding on me and are enforceable under law:

1. I will not, within five years after termination of my employment as a senior appointee in any executive agency in which I am appointed to serve, lobby any officer or employee of that agency.

2. In the event that I serve as a senior appointee in the Executive Office of the President (EOP), I also will not, within five years after I cease to be a senior appointee in the EOP, lobby any officer or employee of any other executive agency with respect to which I had personal and substantial responsibility as a senior appointee in the EOP.

3. I will not, at any time after the termination of my employment in the United States Government, engage in any activity on behalf of any foreign government of foreign government or foreign political party which, if undertaken on January 20, 1993, would require me to register under the Foreign Agents Registration Act of 1938, as amended.

4. I will not, within five years after termination of my personal and substantial participation in a trade negotiation, represent, aid or advise any foreign government, foreign political party or foreign business entity with the intent to influence a decision of any officer or employee of any executive agency, in carrying out his or her official duties.

5. I acknowledge that the Executive order entitle d Ethics Commitments by Executive Branch Appointees, issued by the President on January 20, 1993, which I have read before signing this document, defines certain of the terms applicable to the foregoing obligations and

sets forth the methods for enforcing them. I expressly accept the provisions of that Executive order as a part of this agreement and as binding on me. I understand that the terms of this pledge are in addition to any statutory or other legal restrictions applicable to me by virtue of Federal Government service.

/s/_**[48]**________________________ _**[219]**________________________
SIGNATURE DATE

AGENCY ABC

Serial No. [1097]

[436]

License To Operate Or Navigate Carrying Vessels

[144]

[1015]

This is to certify that **[77, 78, 79, 821]** has given satisfactory evidence to the undersigned that he/she can safely be entrusted with the duties and responsibilities of operator of a mechanically propelled passenger carrying vessel as defined in the Act of May 10, 1956 and is hereby licensed as such for five years from this date.

Given this ________ **[489]**

XYZ City, Alaska **[637] [186]**

John Doe **[50]**
Commandant USCG **[93]**

DG-42
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

LETTERHEAD
[436, 636]

TO: **[77, 78, 79, 821]**
123 Main St. **[74, 75, 1, 73, 17]**
Washington, D. C. 23456

Date: **[489]**
ID: **[746 or 880]**

[1015]

Dear Mr. ____________,

This responds to your request for confirmation of your attendance at the United States Militaryl Academy (or any government organization certifying creditable service).

Our records show that you were enrolled at the United States Military Academy/government organzation from 5 September 1982 [203, 405] to 6 June 1986 [204, **409].**

As you requested, we have sent a copy of this letter to the following personnel office: ABC Agency, 1234 Washington Street, Washington, D. C. 23456. **[16, 998, 619, 5, 625]**

If you have additional questions regarding your enrollment at the Academy/government organization, please contact this office.

Sincerely,
/s/ **[49]**
John Doe **[167]**
Records Chief **[92]**
United States Military Academy

DG 45
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

IN THE SUPERIOR COURT FOR THE STATE OF ABC
AT CITY [30]

In the Matter of the Dissolution of the Marriage of
[77, 78, 79, 821] and _[181]_____________,
Husband and Wife

No. **[1097]**
DECREE OF
DISSOLUTION OF
MARRIAGE

[1015]

Upon consideration of the petition filed in this action and the testimony of the petitioner or petitioners at the hearing on **_____[742]__**, the court makes the following FINDINGS OF FACT AND CONCLUSIONS OF LAW:

1. The court has jurisdiction in this action;
2. Petitioners understand fully the nature and consequences of this action;
3. The agreements between the petitioners concerning child custody, child support, visitation, spousal support, and tax consequences if any, division of property and allocation of obligations are not grossly unfair, unjust or inequitable and are in the best interests of the children of the marriage, if any;
4. The agreements of petitioners as outlined in the petition and any amendments thereto are incorporated as part of these findings;
5. An incompatibility of temperament has caused the irremediable breakdown of the marriage.

THEREFORE IT IS ORDERED:

1. A final judgement of Dissolution of Marriage is hereby granted;
2. Petitioners shall perform their agreements as incorporated in the findings;
3. Petitioner____________________name is restored to _________________
4. Child custody and support: _______________________________________
5. Other relief:____

_/s/_**[48]**_________________ _/s/__**[66]**___________________

DIGITAL OPF
OPF Document Sample with Data Elements

_____**[498]**______________ __/s/__**[52]**_____________
Date Superior Court Judge

I certify that on **__[510]** a copy of this decree was sent to both petitioners.
_[182]___________________
CLERK **[96]**

Agency certification of official seal **[186]**

DG 46
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

THIS IS TO CERTIFY THAT

THE PRESIDENT OF THE UNITED STATES OF AMERICA

AWARDED THE PURPLE HEART MEDAL [976]

TO

[77, 78, 79, 821] - [746]

UNITED STATES ARMY

[1015]

who distinguished himself by outstanding meritorious service in connection with military operations against hostile force in the Republic of Vietnam. During the period

23 April 1970 to 25 August 1970

he consistently manifested exemplary professionalism and initiative in obtaining outstanding results. His rapid assessment and solution of numerous problems inherent in a combat environment greatly enhanced the allied effectiveness against a determined and aggressive enemy. His loyalty, diligence and devotion to duty were in keeping with the highest traditions of the military service and reflect great credit upon himself and the United States Army. Given this **___[490]__**

_/s/_**[52]_________________**
John Doe **[54]**
Colonel, Infantry **[55]**
Commanding

_/s/_**[59]_____________________**
SECRETARY OF THE ARMY **[12]**

Agency Official Seal Certification
[186]

DG 47
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AGENCY LETTERHEAD
[16, 998, 625, 5, 619]

DATE: **[489]**

SUBJECT: Transfer to International Organization

TO: **[77, 78, 79, 821]**

[1015]

This is to advise you the you will be officially released from your ABC Agency position as an Economist on the Management Staff, on February 15, 1997, to transfer for a three-year period to the XYZ Organization of the United Nations in Rome, Italy.

As a career Federal employee with return rights, you are eligible to retain coverage with the resulting rights and benefits under the retirement, health and group life insurance systems as described in 5 CFR, Chapter 1. Part 352 Subpart C (copy enclosed). You are not, however, eligible to continue making contributions to your Thrift Savings Plan Account.

If you choose to maintain your CSRS Offset retirement, basic and optional life insurance, and/or health benefits, you will be responsible for current deposits to the ABC Payroll Office. The ABC Agency will make contributions for any agency portion. The amounts owed will be affected by any pay or benefit plan changes. The ABC Payroll Office will write you shortly after you transfer and confirm which benefits you have elected to retain and tell you how much you owe per pay period. You are responsible for ensuring that your payments reach ABC Payroll Office, Payroll Accounting Section, P.O. Box 123, Washington, D. C. 22345 in a timely manner. Please put your Social Security number on all checks sent to ABC Payroll Office.

Your ABC Agency contact on personnel matters during your FAO assignment will be **[149, 29].**

Please read the enclosed documents very carefully and return them to the person identified above to reflect your understanding of your responsibilities and your decisions concerning benefits.

/s/ **[52]**
John Doe **[54]**
Employment Officer **[55]**

Enclosures

DG 48
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

<table>
<tr><td colspan="7">Department of ABC
SUPERVISORY OR MANAGERIAL PROBATIONARY REPORT</td><td colspan="2">*IMPORTANT*
THIS FORM IS DUE BACK TO THE PERSONNEL OFFICE NO LATER THAN: [711]</td></tr>
<tr><td colspan="2">1. SOCIAL SEC. NO.
[880]</td><td colspan="4">1. NAME (LAST, FIRST, MIDDLE)
[77/78/79/821]</td><td colspan="3">3. PROBATIONARY PERIOD SERVED AS:
Supervisor [992] ❑ Supervisor Manager [993]</td></tr>
<tr><td>4. PAY
[125]</td><td>5. OCCP.
[127]</td><td>3. GRADE
[114]</td><td colspan="3">7. SERVICE PERIOD COVERED THIS RPT
[890] [958]</td><td colspan="3">8. OFFICIAL POSITION TITLE
[80]</td></tr>
<tr><td colspan="2">7. AGENCY CODE
[629]</td><td colspan="3">8. ORGANIZATION STRUCTURE CODE
[25]</td><td colspan="4">9. OFFICIAL DUTY STATION
[938]</td></tr>
</table>

[1015]

The employee named above is serving a supervisory or managerial probationary period that ends on the date shown. The purpose of the probationary period is to provide the agency with the opportunity to assess the employee's supervisory or managerial performance (not technical ability or program knowledge). The supervisor of each employee serving a supervisory or managerial probationary period must determine whether the employee's performance has been fully satisfactory or less that fully satisfactory.

If the employee's performance as a supervisor or manager is less than fully satisfactory, there are issues that must be considered and procedures that must be followed prior to the end of the probationary period. The official signing this form should immediately contact Personnel Resources, Workforce Effectiveness at 123-1234, for guidance and assistance in dealing with this situation.

Please make the required written certification by checking either one of the boxes below, sign and date the certification and return and return to the Personnel Resources, Room 1234, NO LATER THAN 30 DAYS PRIOR to the date the probationary period ends.

CERTIFICATION

[994] I certify that the employee's supervisory or managerial performance is fully satisfactory and have determined that the employee should be retained in the supervisory or managerial position.

[995] I certify that the employee's supervisory or managerial performance is less than fully satisfactory and have determined that the employee should not continue in a supervisory or managerial position (contact Workforce Effectiveness, 123-1234.)

[996]	**[91]**	**[997]**
SIGNATURE OF SUPERVISOR	TITLE	DAT

DG-49
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

AFFIDAVIT OF JOHN D DOE

STATE OF ABC USA **[478]**
County of ABC

[1015]

John D**__[179]_** being first duly sworn, upon oath deposes and says:
1. I am presently the Fire Management Officer of ABC National Forest. I have served in this position since February 1990.

2. I prepare this affidavit on behalf of **[77, 78, 79, 821]** for the purpose of describing his significant service as a Firefighter [80] Prescribed Burner and Law Enforcement Officer on the DEF and GHI National Forests from early 1977 through his reassignment as a Law Enforcement Ranger with the ABC Bureau of Land Management in November, 1989.

3. I began working with ______in March 1977 **[405]** in DEF National Forest. At that time I was assigned as Assistant Foreman. The district is a moderate load fireload district averaging between 30 and 35 fires per year. Mr. ____ attended the required basic firefighting course and became qualified as a Firefighter. During the course of the season, he was dispatched as Crew Firefighter to several fires on DEF National Forest and to the JKL Springs Project Fire.

SUBSCRIBED AND SWORN to before me, the undersigned Notary for this State,
this **____[884, 885, 886]**

___[136]__
NOTARY PUBLIC FOR ANYWHERE
Residing at ABC City **[653],** therein
My Commission expires _________

Official Seal **[186]**

DG 50
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

The University of ABC **[436]**
Health Sciences Center
College of Medicine **[636]**

[489] December 10, 1997

To Whom it May Concern:

From: Robert Roberts, M.D. **[167]**
Professor of Family Medicine **[92]**
789 Main Street
Tulsa, OK 98765 **[636]**

RE: John Smith **[169]**
DOB 1-1-76 **[513]** **[1015]**

Diagnoses: Severe spastic quadriplegia, epilepsy, GERD, mental retardation

I am the family physician for Mr. Smith. This letter is an augmented version of a letter from me dated November 3, 1997.

Mr. Smith's parents need to continue their guardianship of this unfortunate young man. His parents are appropriate for this role as Mr. Smith cannot physically or mentally manage any part of his care. He is totally physically dependent for even the most basic aspects of his personal care. He appears to function in the severe to profound range of mental retardation. This condition has been present since birth and is expected to continue throughout his lifetime. I most recently examined Mr. Smith on November 3, 1997, and confirm that his conditions are permanent. Medical records are available with an appropriately signed release from Mr. Smith's parents. No miracle treatments for his retardation, quadriplegia, or epilepsy are foreseeable. Indeed, minimal improvement is foreseen; rehabilitation is not feasible. His parents provide outstanding care and are the logical choice as his guardians.

If you desire further information regarding this patient, please contact me on (405) 555-1212.

/s/ **[49]**

DG 51
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

U.S. Department ABC **[16]**
XYZ Agency
1234 Main Street
Washington, DC 12345 **[16, 998, 619, 5, 625, 135]**

[489] December 22, 1997

TO: James Jones, M.D. **[54]**
U.S. Department Medical Officer **[55]**

FROM: Jane Williams **[160]**
Personnel Management Specialist **[98]**

[1015]

SUBJECT: Documentation for Self-Support Determination for Employees' Child, John Smith

Attached is medical documentation to support a self-support determination for the child of William Smith who is employed by the FGH Agency. Mr. Smith is requesting that a determination be made at this time to maintain health benefits coverage on his disabled son, John Smith. John will be age 22 on January 1, 1998 and will lose health coverage unless the agency determines he is incapable of self-support. Please review the attached information from his doctor and provide us with your determination as soon as possible so that we may notify the insurance carrier to continue coverage if appropriate.

Please contact me at (202) 555-1212 **[111]**when you have completed your review, or if you have any questions.

/s/ **[61]**

Attachments

DG 51
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

U.S. Department ABC
Office of Assistant Secretary
1234 Main Street
Washington, DC 12345
[16, 998, 619, 5, 625, 135]

December 23, 1997 **[489]**

TO: Jane Williams **[160]**
Personnel Management Specialist **[98]**
XYZ Agency **[16]**

[1015]

SUBJECT: John Smith - Continuation of Health Benefits

This is to recommend continuation of health benefits for John Smith, dependent child of William Smith **[77, 78, 79, 821]**. I have carefully reviewed the medical documentation, and I feel that John Smith is not capable of self-support. He thus is eligible for continued coverage on a permanent basis under his father's Federal Health Insurance in accordance with FPM Supplement 890-1, Subchapter 12, Self-Determination.

Should you have any further questions, please feel free to contact me on **[111]** 202-555-1213.

/s/ **[52]**
James Jones, M.D. **[54, 55]**
Medical Officer

DG 51
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

U.S. Department ABC
XYZ Agency
1234 Main Street
Washington, DC 12345
[16, 998, 619, 5, 635, 135]

[489] January 6, 1998

Blue Cross Blue Shield **[1056]**
Federal Employee Program
550 12th Street, SW
Washington, D.C. 20065

Re: R12345678 **[1097]**

[1015]

We are requesting that health insurance coverage be continued permanently for John Smith, DOB, 01/1/76. John is currently covered as a dependant on his father, William Smith **[77, 78, 79, 821]** (SSN: 123-45-6789 **[880]**), family enrollment with Blue Cross Blue Shield. The agency has determined that John is medically disabled and is incapable of self-support. Therefore, he should remain permanently covered by his father's health insurance. See attached letter from Dr. James Jones, Department ABC Medical Officer, which concurs with our determination.

If you have any questions or need additional information, please contact me at (202) 555-1212 **[111]**.

Sincerely,

/s/ **[61]**

Jane Williams **[160]**
Benefits Officer **[98]**

DG 51
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

FEDERAL EMPLOYEE HEALTH BENEIFTS (FEHB) OPTIONS WHILE IN NONPAY STATUS

Date: **[489]**

Name and Address of Employee: **[77, 78, 79, 821, 1, 73, 17, 74, 75, 135]**

[1015]

You must respond within 31 days (45 days for employees residing overseas) of this notice or your FEHB enrollment will automatically terminate.

Each pay period you are enrolled in FEHB you are responsible for payment of your regular premium. When you enter nonpay status, or your pay is insufficient to cover the premium, you must:

- terminate the enrollment; or
- continue the enrollment and agree to pay the premium or incur a debt.

If you elect to terminate your enrollment (or the enrollment automatically terminates), the termination will take effect at the end of the last pay period in which premiums were withheld from pay. FEHB coverage will continue at no cost to you for an additional 31 days. You and your covered family members may convert to a nongroup contract. The termination is not considered a break in continuous coverage necessary to continuing FEHB coverage into retirement. However, the period during which the termination is in effect does not count toward satisfying the required 5-year continuous coverage. When you return to pay status, or at the end of the first pay period your pay becomes sufficient to cover your premium, you must re-enroll within 31 days if you want FEHB coverage.

If you elect to continue your coverage, you must elect to pay the premiums directly or to incur a debt in the amount of the unpaid premiums. If you elect to pay directly, mail a check or money order payable to U.S. Payroll Office. Include on the check your name, social security number, a note that the check is for “FEHB premium,” and the pay period for which the payment is being made. Mail to:

Health Benefits Premium

DIGITAL OPF
OPF Document Sample with Data Elements

U.S. Payroll Office **[39]**
Collection Officer
P.O. Box 12345
Chicago, IL 12345 **[658]**

If you elect to incur a debt, or if you elect to pay directly but fail to pay the entire amount, the Payroll Office will notify you of the total amount due. The notice will be sent when you return to pay status; your pay becomes sufficient; you separate from employment; or you have been in nonpay status for 365 days. By electing to continue your enrollment you agree that the amount due will be withheld from salary. Therefore, if by the third pay peirod after your pay has become sufficient ot cover the premium(s) you have not paid the full amount, the Payroll Office will begin collection by deducting your regular premium and an additional premium per pay period until the debt is paid. If you separate before the full amount can be collected from your salary, it will be recovered from a lump sum payment of accrued annual leave, income tax refunds, amounts payable under retirement system, or any other source normally available for the recovery of a debt due the United States.

Please indicate your election below and return a copy of this notice to your employing office at:
Payroll Office **[16]**
Personnel Operations Branch
123 North Sixth Street
Minneapolis, MN 54321 **[998, 619, 5, 625, 135]**

After reading and understanding the above, I elect to:

- Continue enrollment (Check one): **[351]** Submit direct payments
  [356] Incur a debt

  (Signature) **[48]** (Date) **[219]**

- Terminate enrollment (Check here): **[334]**

  (Signature) **[161]** (Date) **[183]**

DG 53
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

Employee Name: **[77, 78, 89, 821]** Date: **[489]**

[1015]

The attached Standard Form (SF) 2810, Notice of Health Benefits Enrollment, terminates your group health benefits enrollment effective on the date shown in Part A, block 8, subject to a thirty-one day temporary extension of coverage. The reasons for termination are indicated in Part H, Remarks.

The attached form explains how to convert your coverage to a nongroup contract. If you or family members who were covered by your enrollment wish to obtain individual contract with your health benefits carrier, please read and follow the instructions.

You may enroll again in any plan or option within 60 days of your return to pay and duty status, or of your pay becoming sufficient to withhold a premium, depending on the reason for the termination shown in the remarks Part H of the attached. If you fail to enroll at that time you must wait for an open season or other qualifying enrollment event. Moreover, the break in coverage resulting from the delay in enrollment will be considered when determining whether you have satisfied the continuous coverage requirement for continuing group coverage during retirement.

If your enrollment was terminated because you failed to respond timely to a notice giving you the opportunity to continue coverage, and you believe that you were prevented from responding due to reasons beyond your control, you may request reinstatement of your enrollment. To request reinstatement you must write to the following: (Agency Address) **[16, 998. 619, 5, 625, 135]**, within thirty days of the date of this notice. You must include a description of the circumstances that prevented your timely response with a signed statement indicating whether you will pay for premiums directly on a current basis, or will defer payment until you return to pay status (or your pay otherwise becomes sufficient for the deduction of premiums). If you choose the latter method of payment, you are agreeing that the amount due can be withheld from your salary by deducting the regular premium and an additional premium per pay period, until the debt is paid. If a positive determination is made on your request, this termination will be canceled and your enrollment will be effective retroactive to the date of termination.

If you have questions concerning this notice, please contact Agency Rep. **[149]** on **[106]**.

DG 53
[146]

DIGITAL OPF
OPF Document Sample with Data Elements

FE-8C
EXPLANATION OF BENEFITS
OFFICE OF FEDERAL EMPLOYEES= GROUP LIFE INSURANCE
CLAIM PAYMENT FOR LIVING BENEFITS

CLAIM NUMBER	SOCIAL SECURITY NO.	DATE FE 8 RECEIVED	DATE OF BIRTH	NAME OF INSURED
[1101]	**[880]**	**[488]**	**[468]**	**[77, 78, 79, 821]**

ANNUAL BASIC PAY	LIVING BENEFITS ELECTED	ACTUARIAL REDUCTION	TOTAL
[660]	**[849]**	**[579]**	**[580]**

GROUP NUMBER	THE OFFICE OF FEDERAL EMPLOYEES= GROUP LIFE INSURANCE CANNOT ASSIST YOU IN NEGOTIATING THE CHECK. YOU SHOULD CONTACT A BANK IN YOUR COMMUNITY.
17000-G	

REMARKS: **[931]**

DATE OF THE CHECK: **[489]**

If you have changed your mind and do not wish to claim Living Benefits, **DO NOT CASH OR DEPOSIT THIS CHECK.** Return the check (marked void) to the Office of Federal Employees= Group Life Insurance (OFEGLI), 200 Park Avenue, New York, NY 10166-0188. Once you cash or deposit this check, you **CANNOT CANCEL** your election of Living Benefits.

This check can only be negotiated by the payee. If the payee is deceased, **DO NOT CASH OR DEPOSIT THIS CHECK.** Instead, return it to OFEGLI at the above address. Upon receipt of the returned check, OFEGLI will process the life insurance benefits as if Living Benefits were never claimed.

DATA FOR SF 50:

Elected **[582]** Living Benefits on **[581]**_________________________(NOA Code **[806]**
Living Benefit Amount is **[583]**________________________________

FEDERAL EMPLOYEES GROUP LIFE INS.
200 PARK AVE.
NEW YORK, NY 10166-0188

John Doe **[77, 78, 79, 821]**
1234 Washington Ave
Washington, DC. 23456 **[74, 75, 1,73, 17, 135]**

FE-8C [146]
Date of Form [9]

OF 69 (Rev. 2-89)
U.S. Office of Personnel Management
FPM Chapter 334

ASSIGNMENT AGREEMENT

Title IV of the Intergovernmental Personnel Act of 1970 (5 U.S.C. 3371 - 3376)

INSTRUCTIONS

This agreement constitutes the written record of the obligations and responsibilities of the parties to a temporary assignment arranged under the provisions of the Intergovernmental Personnel Act of 1970.

The term "State or local government," when appearing on this form, also refers to an institution of higher education, an Indian tribal government, and any other eligible organization.

Copies of the completed and signed agreement should be retained by each signatory.

Within 30 days of the effective date of the assignment. two copies of this form must be sent to:

U.S. Office of Personnel Management
Personnel Mobility Program
Staffing Operations Division/CEG
1900 E Street, NW
Washington, D.C. 20415

Procedural questions on completing the assignment agreement form or on other aspects relating to the mobility program should be addressed to either mobility program coordinators in each Federal agency or to the staff of the Personnel Mobility Programs in the U.S. Office of Personnel Management.

PART 1 - NATURE OF THE ASSIGNMENT AGREEMENT

1. Check Appropriate Box

☐ New Agreement ☐ Modification ☐ Extension

PART 2 - INFORMATION ON PARTICIPATING EMPLOYEE

2. Name *(Last, First, Middle)*		3. Social Security Number
4. Home Address *(Street, City, State, ZIP Code)*	5. - A. Have you ever been on a mobility assignment? ☐ YES ☐ NO 5. - B. If "YES", date of each assignment *(Month and Year)* From	To

PART 3 - PARTIES TO THE AGREEMENT

6. Federal Agency *(List office, bureau or organizational unit which is party to the agreement)*	7. State or Local Government *(Identify the governmental agency)*	
8. Is assignment being made through a faculty fellows program? If "YES", give name of the program.	☐ YES	☐ NO

PART 4 - POSITION DATA

A - Position Currently Held

9. Employment Office Name and Address *(Street, City, State and ZIP Code)*	10. Employee's Position Title	11. Office Telephone Number *(Include the Area Code)*
	12. Immediate Supervisor *(Name and Title)*	

B - Type of Current Appointment

13. Federal Employees *(Check appropriate box.)*		14. State and Local Employees	
☐ Career Competitive ☐ Other *(Specify)*:	Grade Level	State or Local Annual Salary	Original Date Employed by the State or Local Government *(Month, Day, Year)*

C - Position To Which Assignment Will Be Made

15. Employment Office Name and Address *(Street, City, State and ZIP Code)*	16. Assignee's Position Title	17. Office Telephone Number *(Include the Area Code)*
	18. Immediate Supervisor *(Name and Title)*	

Previous edition is usable

PART 5 - TYPE OF ASSIGNMENT

19. Check Appropriate Boxes

- ☐ On detail from a Federal agency
- ☐ On leave without pay from a Federal agency
- ☐ On detail to a Federal agency
- ☐ On appointment in a Federal agency

- ☐ Full Time
- ☐ Part Time
- ☐ Intermittent

20. Period of Assignment *(Month, Day, Year)*

From	To

PART 6 - REASON FOR MOBILITY ASSIGNMENT

21. Indicate the reasons for this mobility assignment and discuss how the work will benefit the participating governments. In addition, indicate how the employee will be utilized at the completion of this assignment.

PART 7 - POSITION DESCRIPTION

22. List the major duties and responsibilities to be performed while on the mobility assignment.

PART 8 - EMPLOYEE BENEFITS

23. Rate of Basic Pay During Assignment

24. Special Pay Conditions *(Indicate any conditions that could increase the assigned employee's compensation during the assignment period)*

25. Leave Provisions *(Indicate the annual and sick leave benefits for which the assigned employee is eligible. Specify the procedures for reporting, requesting and recording such leave.)*

PART 9 - FISCAL OBLIGATIONS

Identify, where appropriate, the office to which invoices and time and attendance records should be sent.

26. Federal Agency Obligations *(If paying more than 50 percent of a Federal employee's salary beyond a 6-month period, specify rationale for cost-sharing decision.)*

27. State or Local Government Agency Obligations

PART 10 - CONFLICTS OF INTEREST AND EMPLOYEE CONDUCT

☐ 28. Applicable Federal, State or local conflict-of-interest laws have been reviewed with the employee to assure that conflict-of-interest situations do not inadvertently arise during this assignment.

☐ 29. The employee has been notified of laws, rules and regulations, and policies on employee conduct which apply to him/her while on this assignment.

PART 11 - OPTIONS

30. Indicate coverage **"N/A"**, if not applicable

A. Federal Employees Group Life Insurance

☐ Covered ☐ N/A

B. Federal Civil Service Retirement System or Federal Employees Retirement System

☐ Covered ☐ N/A

C. Federal Employee Health Benefits

☐ Covered ☐ N/A

31. State or Local Agency Benefits *(Indicate all State employee benefits that will be retained by the State or local agency employee being assigned to a Federal agency. Also include a statement certifying coverage in all State and local employee benefit programs that are elected by the Federal employee on leave without pay from the Federal agency to a State or local agency.)*

32. Other Benefits *(indicate any other employee benefits to be made part of this agreement)*

PART 12 - TRAVEL AND TRANSPORTATION EXPENSES AND ALLOWANCES

33. Indicate: (1) Whether the Federal agency or State or local agency will pay travel and transportation expenses to, from, and during the assignment as specified in Chapter 334 of the Federal Personnel Manual, and (2) which travel and relocation expenses will be included.

PART 13 - APPLICABILITY OF RULES, REGULATIONS AND POLICIES

34. Check Appropriate Boxes

☐ **A.** The rules and policies governing the internal operation and management of the agency to which my assignment is made under this agreement will be observed by me.

☐ **B.** I have been informed that my assignment may be terminated at any time at the option of the Federal agency or the State or local government.

☐ **C.** I have been informed that any travel and transportation expenses covered from Federal agency appropriations may be recoverable as a debt due the United States, if I do not serve until the completion of my assignment (unless terminated earlier by either employer) or one year, whichever is shorter.

☐ **D.** I have been informed of applicable provisions should my position with my permanent employer become subject to a reduction-in-force procedure.

☐ **E.** I agree to serve in the Civil Service upon the completion of my assignment for a period equal to that of my assignment. Should I fail to serve the required time, I have been informed that I will be liable to the United States for all expenses (except salary) of my assignment. *(For Federal employees only)*

PART 14 - CERTIFICATION OF ASSIGNED EMPLOYEE

In signing this agreement, I certify that I understand the terms of this agreement and agree to the rules, regulations and policies as indicated in Part 13 above.

35. Location of Assignment *(Name of Organization)*	**36.** Date *(Month, Day, Year)* From	To
37. Signature of Assigned Employee	**38.** Date of Signature *(Month, Day, Year)*	

PART 15 - CERTIFICATION OF APPROVING OFFICIALS

In signing this agreement, we certify that:

- the description of duties and responsibilities is current and fully and accurately describes those of the assigned employee;
- this assignment is being entered into to serve a sound, mutual public purpose and not solely for the employee's benefit;
- at the completion of the assignment, the participating employee will be returned to the position he or she occupied at the time this agreement was entered into or a position of like seniority, status and pay.

State or Local Government Agency	**Federal Agency**
39. Signature of Authorizing Officer	**40.** Signature of Authorizing Officer
41. Date of Signature *(Month, Day, Year)*	**42.** Date of Signature *(Month, Day, Year)*
43. Typed Name and Title	**44.** Typed Name and Title

PRIVACY ACT STATEMENT

Sections 3373 and 3374, Assignment of Employees To or From State or Local Governments, of Title 5, U.S. Code, authorizes collection of this information. The data will be used primarily to formally document and record your temporary assignment to or from a State or local government, institution of higher education, Indian tribal government, or other eligible organization. This information may also be used as the legal basis for personnel and financial transactions, to identify you when requesting information about you, e.g., from prior employers, educational institutions, or law enforcement agencies, or by State, local, or Federal income taxing agencies.

Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which permitted use of the SSN as an identifier of individual records maintained by Federal agencies. Furnishing your SSN or any other data requested is voluntary. However, failure to provide any of the requested information may result in your being ineligible for participation in the Intergovernmental Assignment Program.

U.S. GPO:1989-246-776/00256

Optional Form 306 [146]
September 1994 [9]
U.S. Office of Personnel Management

Declaration for Federal Employment

Form Approved:
OMB No. 3206-0182

50306-101

GENERAL INFORMATION

1 FULL NAME	2 SOCIAL SECURITY NUMBER
➧ [77, 78, 79, 821]	➧ [880]
3 PLACE OF BIRTH (*Include City and State or Country*) ➧ [3]	4 DATE OF BIRTH (*MM/DD/YY*) ➧ [468]
5 OTHER NAMES EVER USED (*For example, maiden name, nickname, etc*) ➧ [1152, 162, 1153, 1154]	6 PHONE NUMBERS (*Includes area code*) DAY ➧ [105] NIGHT ➧ [103]

MILITARY SERVICE

Question	Yes	No
7. Have you ever served in the United States Military Service? If your only active duty was training in the Reserves or National Guard, answer "NO". _	[265]	[921]

If you answered "YES", list the branch, dates (MM/DD/YY) and type of discharge for all active duty military service	BRANCH	FROM	TO	TYPE OF DISCHARGE
	[35]	[203]	[204]	[601]

BACKGROUND INFORMATION

For all questions, provide all additional requested information under item 15 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 8, 9, and 10, your answers should include convictions resulting from a plea of nolo contendere (no contest), but omit (1) traffic fines of $300 or less (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18thbirthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar State law, and (5) any conviction whose record was expunged under Federal or State law.

Question	Yes	No
8 During the last 10 years, have you been convicted, been imprisoned, been on probation or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. _	[917]	[1036]
9 Have you been convicted by a military court-martial in the past 10 years? (If no military service answer "NO".) If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. _	[261]	[922]
10 Are you now under charges for any violation of law? If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	[262]	[925]
11 During the last 5 year, were you fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management? If "Yes", use item 15 to provide the date, an explanation of the problem and reason for leaving, and the employer's name and address. _	[260]	[924]
12 Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes", use item 15 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt. _	[259]	[923]

ADDITIONAL QUESTIONS

Question	Yes	No
13 Do any of your relatives work for the agency or organization to which you are submitting this form? (Includes father, mother husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, daughter/son-in-law, sister/brother-in-law, step family.) If "Yes", use item 15 to provide the name, relationship, and the Department, Agency, or Branch of the Armed Forces for which you relative works.	[264]	[928]
14 Do you receive, or have you ever applied for, retirement pay, pension, or any other pay based on military, Federal civilian, or District of Columbia Government Service? _	[263]	[1149]

CONTINUATION SPACE / AGENCY OPTIONAL QUESTIONS

15 Provide details requested in items 8 through 13 and 17c in the continuation space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position and your agency is authorized to ask them).

[1025]

CERTIFICATIONS / ADDITIONAL QUESTION

APPLICANT: If you are applying for a position and have not yet been selected, Carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, complete item 16/16a.

APPOINTEE: If you are being appointed, Carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initiating and dating all changes and additions. When this form and all attached materials are accurate, complete item 16/16b and answer item 17.

16 I certify that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials is true, correct, complete, and made in good faith. **I understand** that a false or fraudulent answer to any question on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. **I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by *employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists,* and *other authorized employees of the Federal Government.* **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

16a Applicant's Signature *(Sign in ink)* **[48]** — **Date [497]**

16b Appointee's Signature *(Sign in ink)* **[48]** — **Date [219]**

APPOINTING OFFICER: Enter Date of Appointment or Conversion **[221]**

17. Appointee Only ***(Respond only if you have been employed by the Federal Government before):*** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

Question			
17a When did you leave your last Federal job?	Date (MM/DD/YY) **[220]**		
	Yes	No	Don't Know
17b When yu worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance?	**[188]**	**[927]**	**[902]**
17c If you answered "Yes" to item 17b, did you later cancel the waiver(s)? *If your answer to item 17c is "No", use item 15 to identify the type(s) of insurance for which waivers were not canceled.*	**[187]**	**[926]**	**[903]**

Form Approved
OMB No. 3206-0219

OPTIONAL APPLICATION FOR FEDERAL EMPLOYMENT - OF 612

You may apply for most jobs with a resume, this form, or other written format. If your resume or application does not provide all the information requested on this form and in the job vacancy announcement, you may lose consideration for a job.

1 Job title in announcement [80, 125, 127]

2 Grade(s) applying for [433 or 114]

3 Announcement number [1097]

4 Last name [78, 821] First and middle names [77, 79]

5 Social Security Number [880]

6 Mailing address [1, 73]

City [74] State [75, 135] ZIP Code [17]

7 Phone numbers (include area code)
Daytime [105]
Evening [103]

WORK EXPERIENCE

8 Describe your paid and nonpaid work experience related to the job for which you are applying. Do not attach job descriptions.

1) Job title (if Federal, include series and grade) [87, 124, 126, 122]

From (MM/YY) [213] To (MM/YY) [210] Salary $ [665] per [808] Hours per week [696]

Employer's name and address [24, 656]

Supervisor's name and phone number [177, 104] ( )

Describe your duties and accomplishments

[1001]

2) Job title (if Federal, include series and grade) [87, 124, 126, 122]

From (MM/YY) [213] To (MM/YY) [210] Salary $ [665] per [808] Hours per week [696]

Employer's name and address [24, 656]

Supervisor's name and phone number [177, 104] ( )

Describe your duties and accomplishments

[1001]

[146] [9]

9 May we contact your current supervisor?

YES 239 NO 214 If we need to contact your current supervisor before making an offer, we will contact you first.

EDUCATION

960

10 Mark highest level completed. **Some** [ ] HS/GED [ ] Associate [ ] Bachelor [ ] Master [ ] Doctoral [ ]

11 Last high school (HS) or GED school. Give the school's name, city, State, ZIP Code (if known), and year diploma or GED received.

434 633 695

12 Colleges and universities attended. Do not attach a copy of your transcript unless requested.

	Name / City, State, ZIP Code	Total Credits Earned: Semester	Total Credits Earned: Quarter	Major(s)	Degree - Year (if any) Received
1)	Name 176 City 632 State ZIP Code	988		956	692
2)					
3)					

OTHER QUALIFICATIONS

13 Job-related training courses (give title and year). Job-related skills (other languages, computer software/hardware, tools, machinery, typing speed, etc.). Job-related certificates and licenses (current only). Job-related honors, awards, and special accomplishments (publications, memberships in professional/honor societies, leadership activities, public speaking, and performance awards). Give dates, but do not send documents unless requested.

144, 1002, 1003, 1004, 1005

GENERAL

14 Are you a U.S. citizen? YES 573 NO 40 Give the country of your citizenship. 2

15 Do you claim veterans' preference? NO 904 YES 297 Mark your claim of 5 or 10 points below.

5 points 961 ttach your DD 214 or other proof. 10 points 27 Application for 10-Point Veterans' Preference (SF 15) and proof required.

16 Were you ever a Federal civilian employee? NO 1151 YES 435 For highest civilian grade give:

Series	Grade	From (MM/YY)	To (MM/YY)
404	123	439	450

17 Are you eligible for reinstatement based on career or career-conditional Federal status?

NO 178 YES 348 If requested, attach SF 50 proof.

APPLICANT CERTIFICATION

18 I certify that, to the best of my knowledge and belief, all of the information on and attached to this application is true, correct, complete and made in good faith. I understand that false or fraudulent information on or attached to this application may be grounds for not hiring me or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated.

SIGNATURE 48

DATE SIGNED 219

PAY AUTHORIZATION UNDER THE CIVIL SERVICE REFORM ACT OF 1978

Complete this form for your employees or former employees who are entitled to retroactive pay benefits from your agency under Public Law 95-454. See FPM Chapter 536 for further information. Send copies 2 and 3 to the current or last employing agency shown on OPM 1367, Claim For Retroactive Pay Entitlement Under the Civil Service Reform Act of 1978.

I. Employee Identification			
Name of Employee [77, 78, 79, 821]	Date of birth [468]	Social Security Number [880]	Separation date (retiree or deceased) [220]

II. Constructed Employment History, For This Agency - See instructions on reverse					
Pay Plan	Grade	Step	Dates		Rate of Basic Pay
			From (Mo, Day, Yr)	To (Mo, Day, Yr)	
[130]	[129]	[131]	[201]	[202]	[660]
Agency Use [931]			Signature [52]		Date [490]

III. Computation of Retroactive Benefits (See instructions on reverse and FPM Chap. 536)

Retroactive period covered by retroactive entitlement: From: [222] To: [223]

A. Type of Pay	B. Amount Received		C. CSRA Entitlement		D. Amount Due Employee
Basic Rate of Pay [660]	[676]		[678]		[677]
Premium Pay (Identify) [1041]	[832]		[834]		[833]
Allowances and Differentials (Identify) [674]	[675]		[673]		[672]
Other Pay (Identify) [1040]	[826]		[831]		[830]
Total Retroactive Entitlement					[837]
Minus Deductions (Federal, State, Local taxes, life insurance)	Federal tax [680]	State tax [835]	Local tax [682]	Life Insurance [681]	[836]
Total to Employee					[679]
Agency Use [935]					
Signature of Approving Official [59]	Agency Name and Location [16, 5, 998, 619, 625]				Date [500]

Office of Personnel Management
MILITARY DEPOSIT WORKSHEET

1. Name [77, 78, 79, 821]		2. Date of Birth [468]	3. Social Security Number [880]		4. Date of Computation [708]
5. Period of Military Service		6. Total Service in Period (Years, Months, Days) [790, 788, 789]	7. Amount of Earnings $ [839] x	8. Withholdings Percentage [845] =	9. Amount of Deposite Due $ [838]
From (Month, Day, Year) [203]	To (Month, Day, Year) [204]				
10. Agency [16]			11. Interest Accrual Date [709]		12. [275] CSRS [276] FERS

INTEREST COMPUTATION

Date	Amount Due	Rate/Interest	Total Due
[710]	[841]	[843]	[844]

RECORD OF PAYMENTS

Date	Payment	Balance Due
[707]	[842]	[840]

[146, 9] OPM FORM 1514
MARCH 1991

CSRS — Service Credit Payments for Post-1956 Military Service — FERS

Chapter 23

Military Service Deposit Election

1. Employee's name	2. Date of birth	3. Social Security Number

4. Does employee appear eligible for annuity based on minimum basic annuity? ☐ Yes ☐ No	5. If item 4 is "yes", would deposit for military service increase annuity? ☐ Yes ☐ No

Our records indicate that you had military service after 1956 and are eligible for an annuity. If you are a CSRS employee who was first employed before October 1, 1982, and you are entitled (or will be entitled at age 62) to a Social Security benefit that includes credit for post-1956 military service, you must either make a deposit for the military service or have your annuity benefits reduced at age 62 (or at the time of your retirement if you are then age 62 or older) unless you are eligible for a minimum basic annuity that is not affected by the inclusion of your military service. If you are a CSRS employee who was first employed after September 30, 1982, you must make a deposit for your military service in order to have it included in the computation of your annuity.

Instructions to Employee: Your decision about making this deposit may affect your rights under CSRS:

1. Please read the attached "Information for Completing OPM Form 1515" carefully to be sure you understand the consequences of not making the deposit for military service.
2. If you decide to make the deposit for military service with the employing agency, ask for instructions from the personnel office identified below.
3. Check the appropriate box below to indicate whether you will make or complete the deposit or not and return two copies of this form to the personnel office at the address below.

Return completed election form to: (Agency Personnel Office address)	Election must be received by (date)

Employee Election

I read the information concerning my rights to make a deposit for post-1956 military service. (Mark an "x" in the appropriate box below to indicate your election.)

☐ I want to make (or complete) this deposit. I will make the necessary payment to my employing agency.

☐ I do not want to make (or complete) this deposit.

Signature	Date

Instructions to Employing Office

This form must be completed when an employee retires and agency records show that the employee has not made or completed a deposit for post-1956 military service. Give the employee three (3) copies of this form and these instructions for completing the form. Have the employee return two (2) signed and dated copies of the form. Attach one to the employee's records when you send them to OPM. If the employee does not return a signed copy before you forward the records to OPM, note above the signature line "Employee did not return election form." The employee should also be counseled regarding the minimum basic annuity if the payment of the deposit will not increase the annuity.

OPM Form 1522

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
CIVIL SERVICE RETIREMENT SYSTEM
WASHINGTON, D.C. 20415

Request for Offset for Past-Due Health Benefits Premiums
From Monies Payable Under the Civil Service Retirement System
(In Lieu of SF 2805)

The former employee named below is indebted to the United States (under Section 890.502 (b) of the Title 5, Code of Federal Regulations) for past-due health benefits premiums. To liquidate this indebtedness, we request that you set off the gross amount of the debt as shown below, against the former employee's account in the Civil Service Retirement and Disability Fund. The former employees retirement record (Standard Form 2806) is (is not) attached.

Name and address of office designated by the employing agency to receive evidence of the liquidation of the debt: (Please use the first three lines for agency name and P.O. Box or street address; use last line for city, state, and zip code.)

[14, [469]

ABC Agency
Finance Office
123 Main Street
Washington DC 20001

[77, 78, 79, [821]

Name of former employee:
Mary Smith

Date of Birth:		Date of Termination of Service:		Social Security Number:	
01-14-60	**[468]**	07-01-88	**[220]**	000-00-000	**[880]**

Each period of non-pay status for which offset is required:

From **[1109]**	To **[1113]**	Amount of debt for each period:		Total amount of debt:	
05-08-88	07-02-88	66.00	**[117]**	66.0	**[1118**
- -	- -	.			
- -	- -	.			
- -	- -	.			

Location of Employment: (City, State)
Baltimore MD **[8]**

Appropriation and or Fund (Title) Symbol No. **[32]** **[797]**

Disbursing Office **[39]** Symbol **[1119]**

I certify that this debt is property due the United States, that all other means of recovery have been exhausted, and that the individual from who the collection is sought was given an opportunity for reconsideration of the collection before this request was made.

Signature of Certifying Official **[52]**	**Date** **[490]**	**Name of Certifying Official (Typed or printed)** **[54]**
Title of Certifying Official (Typed or printed) **[55]**		**Telephone Number (Including Area Code)** ( ) **[108]**

NOTIFICATION OF EARNINGS FOR MEDICARE ELIGIBILITY

To be completed for employees employed during January 1983 if:
a. separating
b. old enough to qualify for Medicare

(Prepare in duplicate - one copy for employee and one for OPF)

1. Name of Employee (Last, first, middle)	2. Date of Birth (Month, day, years)	3. Social Security Number
[77, 78, 79, 821]	**[468]**	**[880]**

4. Indicate Dates of Employment Prior to January 1, 1983

Beginning Date (Month, day, year)	Ending Date (Month, day, year)
[205]	**[206]**

5. Gross Federal Earnings for Each Calendar Year Prior to 1983 (Note: Maximum number of years necessary is 10)

Year	Earnings	Year	Earnings
[712]	**[846]**	**[753]**	**[869]**
[749]	**[865]**	**[754]**	**[870]**
[750]	**[866]**	**[755]**	**[871]**
[751]	**[867]**	**[756]**	**[872]**
[752]	**[868]**	**[748]**	**[873]**

6. Remarks

YOU MAY NEED THIS INFORMATION IN THE FUTURE TO QUALIFY FOR MEDICARE

Under the law, individuals who were Federal employees on January 1, 1983, began paying the Medicare hospital insurance portion of the Social Security (FICA) tax.

You qualify for Medicare hospital insurance at age 65 if you have enough quarters of coverage. The maximum quarters needed is 40, or 10 years of service. Earnings for the 10 years prior to mandatory coverage are shown above (or from date of hire, if later). An individual who was a federal employee both before January 1983 and at any time during January 1983 will be given credit for Federal employment prior to 1983 if they need it to qualify. When you become age 65 or if you become totally disabled, you may need the above information to qualify for Medicare coverage.

There is no cost for the hospital insurance for eligible individuals beginning at age 65. Benefits include limited inpatient hospital care in a hospital or skilled nursing facility and home health care visits, in addition to hospice care for the terminally ill.

Please safeguard this document. It is your responsibility to take this form to the Social Security Administration when filing for Medicare benefits.

The data used in item 5 was obtained from retirement records which include only base pay. It should only be used to determine Medicare eligibility. It may differ from what was reported on the W-2, Wage and Tax Statement.

7. AGENCY CERTIFICATION

I CERTIFY that the information above accurately reflects verified information contained in offical personnel and/or payroll records in the custody of this agency.

7a. Signature of Certifying Official		8. Agency Name and Address
[52]		**[16, 5, 998, 619, 625]**
7b. Official Title	7c Date	
[55]	**[490]**	

EMPLOYEE NOTE: Keep this form in a safe place. You will need it to apply for Medicare benefits when you become eligible.

REPRODUCE LOCALLY

Retirement Election for Certain Senior Officials

Federal Employees Retirement System

Section 1. Instructions for Officials

- See Privacy Act information on page 2.
- Read Information on page 3 and 4 of this form.
- Make your election in Section 3.
- Sign in Section 5.
- Be sure to read the FERS Transfer Handbook.
- If you elect FERS, any CSRS designation of beneficiary (2808) is cancelled. If you want to make a new designation of beneficiary, use SF 3102.

Section 2. Identifying Information (type or print)

Name (Last, first, middle) **[77, 78, 79, 821]**	Date of Birth (mo., dy, yr) **[468]**	Social Security Number **[880]**

Section 3. Election of Retirement Coverage

Place your initials in one of the boxes below to indicate your choice of retirement coverage. (Initial only one box.)

A. Election of FERS-
This election is available to all eligible officials.
☐ I elect FERS coverage. I understand that I will continue to be covered under Social Security. I understand that this decision is irrevocable. (If you initial this box, you must also complete Section 4.)
[53]

B. Election of CSRS Offset -
This selection is available to all eligible officials.
☐ I elect CSRS Offset coverage. I understand that I will continue to be covered under Social Security. I authorize withholdings be made from my pay for both CSRS Offset and Social Security coverage.
[53]

C. Election of Full CSRS-
This election is available only to those officials who now have full CSRS.
☐ I previously elected full CSRS coverage and I want that election to stand. I understand that I will continue to be covered by Social Security. I authorize withholdings be made from my pay for full CSRS coverage (7, 7 1/2, or 8% of pay, as applicable) and Social Security coverage.
[53]

D. Election of No Retirement Coverage-
This election is available only to those officials who have no coverage because of their previous election.
☐ I previously elected to have no retirement coverage in addition to my Social Security coverage and I now want that election to stand. I understand that I cannot participate in the Thrift Savings Plan.
[53]

Section 4. Former Spouse Information If you initialed box A above, you must complete this Section. If you initialed box B, C, or D, above, skip to Section 5.

Do you have a living former spouse who has not remarried before reaching age 55 to whom a court order, on file at OPM, awards portion of your annuity or survivor benefits based on your Federal service?

☐ **[282**] Yes Attach OPM Form 1556, Former Spouse's Consent to FERS Election, your request for waiver of consent requirement, or your request for extension of election deadline in order to modify court order.

☐ **[281]** No

☐ **[280]** I don't know if a court order is on file at OPM. I have attached OPM Form 1560 requesting OPM to determine whether qualified court order is on file.

Section 5. Employee's Certification

I hereby certify that all statements made on this election are true to the best of my knowledge.

Signature **[48]**	Date **[219]**
	Date of receipt by agency **[499]**

[146] OPM Form 1561
[9] June 1987

OPM Form 1583 (10/89) [146, 9]
U.S. Office of
Personnel Management

Applicant's Statement of Selective Service Registration Status

Form Approved:
O.M.B. No. 3206-0168
Expires October 1992

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires you must be registered with the Selective Service System, unless you meet certain exceptions under Selective Service law. If you are required to register but knowingly and willfully fail to do so, you are ineligible for appointment by executive agencies of the Federal Government.

CERTIFICATION OF REGISTRATION STATUS *(Check one)*

[258] I certify I am registered with the Selective Service System

[256] I certify I have been determined by the Selective Service System to be exempt from the registration provisions of Selective Service law.

[257] I certify I have not registered with the Selective Service System.

[255] I certify I have not reached my 18th birthday and understand I am required by law to register at the time.

NON-REGISTRANTS UNDER AGE 26

If you are under age 26 and have not registered as required, you should register promptly at a United States Post Office, or consular office if you outside the United States.

NON-REGISTRANTS AGE 26 OR OVER

If you were born in 1960 or later, are 26 years of age or older, and were required to register but did not do so, you can no longer register under Selective Service law. Accordingly, you are not eligible for appointment to an executive agency unless you can prove to the Office of Personnel Management (OPM) that you failure to register was neither knowing nor willful.

You may request an OPM decision through the agency that was considering you for employment by returning this statement with your written request for an OPM determination together with any explanation and documentation you wish to furnish to prove that your failure to register was neither knowing nor willful.

PRIVACY ACT AND PUBLIC BURDEN STATEMENT

Because information on your registration statis is essential for determining whether you are in compliance with 5 U.S.C. 3328, failure to do provide the information requested by this statement will prevent any further consideration of your application for appointment. This information is subject to verification with the Selective Service System and may be furnished to other Federal agencies for law enforcement or other authorized use in implementing this law.

Public burden reporting for this collection of information is estimated to take approximately one minute per response, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Reports and Forms Management Officer, U.S. Office of Personnel Management, 1900 E. Street, N.W., Room 6410, Washington, D.C. 20415; and to the Office of Management and Budget, Paperwork Reduction Project (3206-0166), Washington, D.C. 20503.

FALSE STATEMENT NOTIFICATION

A false statement may be grounds for not hiring you, or for firing you if you have already begun work. Also, you may be punished by fine or imprisonment. (Section 1001 of title 18, United States Code.)

Legal Signature of Applicant	Date Signed
[48]	**[219]**

ESTIMATED EARNINGS DURING MILITARY SERVICE

INSTRUCTIONS: Use a separate RI 20-97 for each branch of service. Attach DD 214 or equivalent and any available records of pay or promotions. If you do not have a DD 214 or equivalent, obtain an SF 180 from your personnel office and have your service verified before forwarding this form to the pay center. The pay center cannot provide estimated earnings unless verification of service is attached.

To

[15, 584]

Employee name (Last, First, Middle) [77, 78, 79, 821]	
Other names used [1152, 162, 1153, 1154]	
Social Security Number [880]	Date of birth [468]
All military service numbers [746]	
Branch of Service [35]	

The uniformed services must provide estimated basic pay by Federal employees for military service after December 31, 1956, for the purpose of making a deposit to the Civil Service Retirement and Disability Fund for retirement credit. Please provide the estimated basic pay earned by the above named employee.

Signature of requester	Relationship to employee	Date
[57]	[321]**Employee is requester** [320] **Other (Specify** [585] **Survivor** [1145]	[484]

Active military service after December 31, 1956 (Dates indicated below must be based on DD 214 or equivalent certification		TO BE COMPLETED BY AUTHORIZED OFFICIAL Estimated Earnings (Base Pay) (Do not provide estimated earnings for any period of service prior to January 1, 1957.)				
From (Mo,Dy,Yr)	To (Mo,Dy,Yr)	From (Mo,Dy,Yr)	To (Mo,Dy,Yr)	Rate of Basic Pay	Earnings	Type of Discharge
[465]	[466]	[1140]	[467]	[587]	$ [839]	[601]
					$	
					$	
					$	
					$	

1. If period of service began before and ended after December 31, 1956, enter date service actually began. (Mo,Dy,Yr)

[203]

2. Lost time

[590] **None** [592] **Number of days** _[691] ________________

Inclusive dates	From(Mo,Dy,Yr)	To(Mo,Dy,Yr)	From(Mo,Dy,Yr)	To(Mo,Dy,Yr)
[593]	[594]	[595]		

Signature of authorized official furnishing estimate	Date(Mo,Dy,Yr)	Telephone number (Including Area Code)
[52]	[490]	[108]

Typed name of authorized official [54]

Title of authorized official [55]

Requester's name and address

[148, 479]

= Return Completed Form to

Retirement, Life Insurance, and Health Benefits
under the
Indian Self-Determination and Educational Assistance Act-Public Law 93-638

1 Instructions for completing form:

- $ Read the instructions on the back carefully before filling out form.
- $ Be sure ALL COPIES of the form are legible. Type or print in ink.
- $ Keep all four (4) copies of the form together.

2 Fill in the Identifying Information Below (Please print or type):

Name (Last) (First) (Middle)	Date of Birth (Mo.,Day,Yr.)	Social Security No.
[77, 78, 79, 821]	[468]	[880]

Employing Department or Agency	Agency Location (City, State, Zip Code, and Fax No.)
[16]	[998, 619, 625, 88]

Have you ever before filed this Form? [157]____ Yes [953]____ No
If "Yes," do not file this form again, your last form remains in effect.

3 By law, a person who elects to leave Federal employment to be employed by a tribal organization in connection with governmental or other activities which are or have been performed by employees in or for Indian communities is entitled, if the employee and the tribal organization so elect, to retain certain benefits.

IMPORTANT: Election of coverage must be made prior to employment by tribal organization and documented on this form prior to the effective date of the employee's resignation. Failure to file this form will result in the loss of retirement, life insurance, health benefits coverage, and continuation of the Thrift Savings Plan.

Employee Elections-- Mark an "X" by the benefits you wish to retain:

[524]__ A. Retirement [275]CSRS [276] FERS
[194]__ B. Health Insurance
[193]__ C. Basic Life Insurance
[375]__ D. Option A--Standard Life Insurance
[372]__ E. Option B--Additional Life Insurance with the following multiples of pay:
[342]__ **1** [343]__ 2 [344]__ 3 [345]__ 4 [346]__ 5
[520]__ F. Option C--Family Life Insurance
[180]__ G. Thrift Savings Plan (must retain **retirement coverage)**
[353]__ H. No Benefits at All

Tribal Organization -- Mark an "X" by the benefits for which you wish to make a contribution.

[354]__ I. Retirement [444]CSRS [445]FERS
[446]__ J. Health Insurance
[447]__ K. Life Insurance
[503]__ L. Thrift Savings Plan
[509]__ M. No Benefits at All

4 Employee must sign and date, and then have the tribal organization complete its sections. Return the entire set of four forms to the employing office along with a transmittal memorandum.

Employee's Signature (Do not print)
[48]

Date [219]

FOR USE OF FEDERAL AGENCY ONLY

(Official Receiving Date Stamp)
[499]

Signature of Authorized Tribal Official
[52]

Title and Name of Organization
[55, 30]

Address
[477, 478, 480, 481]

Telephone Number (including area code)
[108]

Date
[490]

ELECTION TO RETAIN NAFI RETIREMENT COVERAGE AS A RESULT OF A MOVE FROM A NONAPPROPRIATED FUND POSITION TO A CIVIL SERVICE POSITION ON OR AFTER AUGUST 10, 1996

INSTRUCTIONS: The Personnel Office must verify that the employee was vested in the NAFI retirement plan before completing Part 1 of this form and giving it to the employee. The employee must indicate his/her election by signing in Part 3 and returning the signed form to the Personnel Office on or before the due date shown in Part 1.

PART 1 (to be completed by agency)	I verify that in accordance with §§ 8347(q) and 8461(n) of title 5, U.S.C., and OPM regulations at 5 CFR 847.205, this employee is eligible to retain coverage in the NAFI retirement plan because he/she --	
Employee's name **[77, 78, 79, 821]**	(1) Has never previously had an opportunity to elect to retain coverage in a NAFI retirement plan;	
Date of Birth **[468]** / Social Security Number **[880]**	(2) Has moved, on or after August 10, 1996, from a NAFI position subject to a NAFI retirement plan to a civil service appointment covered by CSRS or FERS without a break of more than 1 year; and	
Name of NAFI Retirement Plan **[514]**	(3) is vested in the NAFI retirement plan as of the date of the move	Date of Move **[596]**
	Authorized Signature **[52]**	Date signed **[490]**
Due Date: Personnel Office Must Receive Election On or Before **[711]**	Title **[55]**	

PART 2: ACKNOWLEDGEMENT OF RECEIPT AND NOTICE OF EFFECT OF FAILURE TO ELECT

I understand that I am eligible to retain retirement coverage in the NAFI retirement plan listed above. I acknowledge that the Personnel Office has completed Part 1 of this election form and given it to me on this date. I understand that if I fail to complete Part 3 and return the completed form to the Personnel Office before the close of business on the Due Date (shown in Part 1) I will automatically be considered to have chosen Option 2 in Part 3. I also understand that the option I choose below (or am automatically considered to have chosen) will restrict my retirement plan entitlement for the rest of my Government career and that I can never change this election.

Employee's signature **[48]**	Date **[506]**

PART 3: EMPLOYEE'S ELECTION (Instructions to employee: Sign only the box for the option that you elect.)

OPTION 1: I elect to retain retirement coverage in the NAFI retirement plan. I understand that because of this irrevocable decision, I will never be able to earn additional credit under the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). I understand that regardless of future moves between NAFI and civil service employment, breaks in service, and changes in employment or retirement status, my retirement coverage will remain with a NAFI retirement plan in accordance with the rules of that plan.

Employee's signature **[161]**	Date **[219]**

OPTION 2: I do not elect to retain retirement coverage in the NAFI retirement plan. Because I have made this decision:

1) I will enter FERS (or CSRS Offset if appropriate) coverage without receiving any service credit in FERS (or CSRS Offset) for time spent under the NAFI plan.

2) I will not be given another opportunity to retain coverage in a NAFI retirement plan, if I ever move from a NAFI position to a civil service appointment in the future. However, if I move back to a NAFI position, I will be subject to the NAFI plan in accordance with its rules.

3) If in the future I move back to NAFI employment, including employment covered by the NAFI retirement plan that I am leaving, I will be given a one-time opportunity (if I never before have been given the opportunity) and if I have 5 years of creditable service under FERS or CSRS) to elect to retain coverage in FERS (or CSRS Offset), or to enter the appropriate NAFI plan without transfer of FERS (or CSRS Offset) service credit.

Employee's signature **[608]**	Date **[183]**

✧
FEGLI
Federal Employees Group Life Insurance

Assignment of Federal Employees' Group Life Insurance

IMPORTANT
Read Instructions on the back of Copy 2 **before** completing this form.

Part A - *General Instructions*

Use this form to assign (transfer ownership of) your life insurance coverage to another individual(s).

To complete the form:

- Read the information on the back of Copy 2 carefully.
- Read the Statement of the Insured in Part D, then fill in the requested information in Parts B, C, and D.
- Type or print in ink.
- Sign, and have the witnesses sign, in ink
- Don't separate the parts
- Submit the completed form to your employing office or retirement system

Your employing office or retirement system will certify the completed form and will return your copy to you.

Part B - *Identifying Information*

1.Name (Last, First, Middle)	2. Date of Birth (month, day, year)	3. Social Security Number
[77, 78, 79, 821]	[468]	[880]

4. If you are retired or receiving Federal Employees' Compensation, give your "CSA", "CSI", or OWCP claim number → [1101]

5. Home mailing address (number, street, city, state, ZIP code)	6. Name and address of your employing office or former employing office, if retired
[74, 75, 1, 73, 17, 135]	[998, 619, 5, 625, 16]

Part C - *Assignment to Individual(s) or Trust(s)*

Complete blocks 1 through 4. **If you're assigning to two or more individuals, indicate percentage of shares.** The share of any living assignee will be paid to the assignee's designated beneficiary or, if none has been designated, to the assignee. In the case of an assignee who predeceases you, the share will be paid to his or her beneficiary or, if none has been designated, or the beneficiary predeceased you, to the assignee's estate. If you're assigning to a Trust, include the name of the trustee and any successor trustee, the date and title of the Trust Agreement, and the names of the persons who signed it. **Each assignee should complete a Designation of Beneficiary Form (SF 2823).**

Note: It is possible that assignment to a trust may not exclude FEGLI benefits from your estate. It is also possible that, through designation of beneficiary or inheritance, you could reacquire the FEGLI coverage. Before making the assignment, you should **consult you tax attorney** about possible tax consequences if you want to make an assignment to a revocable or irrevocable trust, or wish to avoid inheriting the FEGLI coverage upon the death of your assignee(s).

1. First name, middle initial and last name of assignee (or trust information)	2. Address	3. Relationship	4. Share (%)
[76]	[893]	[896]	[899]

Part D - *Statement of the Insured*

Complete blocks 1 and 2 and have two people witness your signature and complete blocks 3a and 3b.

Statement of the Insured: I, the insured, revoke all previous designations of beneficiary (ies) and assign all present and future right, title, interest, and incidents of ownership in my Federal Employees' Group Life Insurance (FEGLI) coverage (except family optional insurance) to the Assignee (s) designated above. I understand that premium payments will be withheld from my salary, annuity, or compensation to pay for this coverage. I also understand that for as long as I am continuously insured for FEGLI coverage, I can never revoke this assignment and can never cancel premium withholdings (except the premium withholdings for any family optional insurance I may have). I verify that I have read the explanation of this assignment on the back of Copy 2 or this form.

1. Insured's signature	2. Date signed (mo., day, yr.)
[48]	[219]

3. Witnesses to Insured's signature (Assignees may not be witnesses)

	Name (Print or Type)	Date	Signature	Number and Street	City, state, ZIP code
a	[174]	[905]	[64]	[645]	[646]
b	[175]	[910]	[65]	[651]	[652]

Part E - *Receipt by Employing Office or Retirement System*

I CERTIFY receipt of this assignment of insurance coverage.

Name (Print or Type)	Title	Signature	Name and address of employing office or retirement system	Date of receipt
[54]	[55]	[52]	[16, 470]	[499]

ELECTION OF RETROACTIVE NAFI RETIREMENT COVERAGE BY FERS EMPLOYEES UNDER PUBLIC LAW 104-106

Instructions for completing this form are in Benefits Administration Letter 96-108, dated September 6, 1996.

PART 1. TO BE COMPLETED BY EMPLOYING AGENCY

1. Employee Name	2. Date of Birth (Month, day, year)	3. Social Security number
[77, 78, 79, 821]	[468]	[880]

4. Employing agency and mailing address	5. Effective Date of Election (Date of qualifying move)	6. Name\telephone number of agency contact
[998, 619, 5, 625, 16]	[596]	[149, 106]

7. The following period of service will become subject to nonappropriated fund instrumentality (NAFI) retirement coverage by this election:	Beginning date	Ending date
	[405]	[409]

8. Total amount available for transfer to the NAFI Retirement Plan as of (Date) [89]: $ [141] (Amount)

9. I verify that in accordance with the provisions of section 1043 of Public Law 104-106, and OPM regulations at 5 CFR part 847, Subpart D, this employee is eligible to elect NAFI retirement coverage retroactive to the date of the qualifying move shown in block 5 above.

Authorized signature and title	Date signed
[52, 55]	[490]

PART 2. ACKNOWLEDGEMENT OF RECEIPT

I understand that I am eligible to elect coverage under a NAFI retirement system. I am also aware of the right to make an alternative election to remain in the Federal Employees Retirement System (FERS) with service credit for past NAFI service. I acknowledge that the Personnel Office has completed Part 1 of this election form and given it to me on this date. I understand that if I wish to be covered by the NAFI retirement system retroactive to the date of my qualifying move (shown in Part 1, block 5), I must return the completed form to the Personnel Office before the close of business on August 11, 1997 (if mailed, the envelope must be postmarked no later than August 11, 1997). I also understand that if I fail to return this form to my Personnel Office before August 11, 1997, I will remain covered by FERS, in accordance with FERS rules.

Signature of employee	Date
[48]	[506]

PART 3. TO BE COMPLETED BY EMPLOYEE

I elect to be covered by the NAFI retirement plan. I understand that because of this irrevocable election, I will never be able to earn additional credit under FERS. I understand that regardless of future moves between civil service employment and NAFI employment, breaks in service, and changes in employment or retirement status, my retirement coverage will remain with the NAFI plan in accordance with the rules governing the NAFI plan. I also understand that this election does not affect any service performed before the effective date of this election (as shown in Part 1, block 5).

I understand that because of my election, my civilian service subject to FERS since the date of my qualifying move (shown in Part 1, block 5) will become subject to the NAFI retirement plan. Any unrefunded contributions made by me or on my behalf to FERS since the effective date of this election (shown in Part 1, block 5) will be transferred to the NAFI retirement plan. If the amount transferred does not fully fund the actuarial present value of the increase in my NAFI retirement benefit, I understand that my NAFI benefit will be reduced in a manner consistent with 5 CFR part 847, Subpart F.

Signature of employee	Date signed
[161]	[219]

ELECTION OF FERS WITH CREDIT FOR NAFI SERVICE UNDER PUBLIC LAW 104-106

Instructions for completing this form are in Benefits Administration Letter 96-108, dated September 6, 1996.

PART 1. TO BE COMPLETED BY EMPLOYING AGENCY

1. Employee Name	2. Date of Birth *(Month, day, year)*	3. Social Security number
4. Employing agency and mailing address	5. Date of qualifying move	6. Name\telephone number of agency contact

7. The following period(s) of service with a nonappropriated fund instrumentality (NAFI) will become creditable for Federal Employees Retirement System (FERS) purposes by this election:

Beginning date	Ending date

8. Total amount available for transfer to the Civil Service Retirement and Disability Fund as of *(date)*__________________________: $ *(Amount)*

9. I verify that in accordance with the provisions of section 1043 of Public Law 104-106, and OPM regulations at 5 CFR part 847, Subpart D, this employee is eligible to elect FERS with credit for the above periods of NAFI service.

☐ *(Check if applicable)* I have also determined that this employee is eligible to elect NAFI retirement coverage and has been given the appropriate form for that election.

Authorized signature and title	Date signed

PART 2. ACKNOWLEDGEMENT OF RECEIPT

I understand that I am eligible to elect FERS with credit for the above NAFI service (shown in block 7) under FERS. I acknowledge that the Personnel Office has completed Part 1 of this election form and given it to me on this date. I understand that if I wish to elect FERS service credit for my NAFI service, I must return the completed form to the Personnel Office before the close of business on August 11, 1997 (if mailed, the envelope must be postmarked no later than August 11, 1997). I also understand that if I fail to return this form to my Personnel Office before August 11, 1997, that my prior NAFI service will not be creditable for any purpose under FERS.

Signature of employee	Date

PART 3. TO BE COMPLETED BY EMPLOYEE

I elect credit under FERS for the NAFI service shown above in Part 1, block 7. I understand that by making this irrevocable election, I will remain covered by FERS, in accordance with FERS rules, for all future Federal service and I will never be able to earn additional credit under a NAFI retirement plan. I also understand that because of this election, the NAFI service shown in Part 1, block 7 ceases to be creditable for any purpose under a NAFI retirement plan.

I understand that because of my election, my NAFI service shown above will become creditable under FERS. Any unrefunded contributions made by me or on my behalf to the NAFI retirement system will be transferred to the Civil Service Retirement and Disability Fund. If the amount transferred does not fully fund the actuarial present value of the increase in my FERS annuity, I understand that my FERS annuity will be reduced in accordance with 5 CFR part 847, Subpart F.

Signature of employee	Date signed

Reproduce Locally

September 1996

Standard Form 15 (Rev. 2/90)
U.S. Office of Personnel Management
FPM Supplement 296-33
FPM Chapter 211

146, 9

APPLICATION FOR 10-POINT VETERAN PREFERENCE

(TO BE USED BY VETERANS & RELATIVES OF VETERANS)

Form Approved
OMB No. 3206-0001

PERSON APPLYING FOR PREFERENCE

1. Name (Last, First, Middle) 77, 78, 79, 821

2. Name and Announcement Number of Civil Service or Postal Service Exam You Have Applied For or Position Which You Currently Occupy 1051

3. Home Address (Street Number, City, State and ZIP Code) 74, 75, 1, 73, 17, 135

4. Social Security Number 880

5. Date Exam was Held or Application Submitted 485

VETERAN INFORMATION (TO BE PROVIDED BY PERSON APPLYING FOR PREFERENCE)

6. Veteran's Name (Last, First, Middle) Exactly As It Appears on Service Records 1096

7. Veteran's Periods of Service

Branch of Service	From	To	Service Number
35	203	204	746

8. Veteran's Social Security Number 1095

9. VA Claim Number, If Any 1102

TYPE OF 10-POINT PREFERENCE CLAIMED

INSTRUCTIONS: Check the block which indicates the type of preference you are claiming. Answer all questions associated with that block. The "DOCUMENTATION REQUIRED" column refers you to the back of this form for the documents you must submit to support your application . [PLEASE NOTE: Eligibility for veterans' preference is governed by 5 U.S.C. § 2108, 5 CFR Part 211, and FPM chapter 211. All conditions are not fully described in this form because of space restrictions. The office to which you apply can provide additional information. Instructions on how to apply for five point preference are on SF 171, Personal Qualifications Statement, or PS Form 2591, Application for Employment (U.S. Postal Service Application).]

DOCUMENTATION REQURED (See reverse of this form.)

☐ 10. 312 VETERAN'S CLAIM FOR PREFERENCE based on non-compensable service-connected disability; award of the Purple Heart; or receipt of disability pension under public laws administered by the VA. .... A and B

☐ 11. 311 VETERAN'S CLAIM FOR PREFERENCE based on eligibility for or receipt of compensation from the VA or disability retirement from a Service Department for a service-connected disability. .... A and C

☐ 12. 298 PREFERENCE FOR SPOUSE of a living veteran based on the fact that the veteran, because of a service-connected disability, has been unable to qualify for a Federal or D.C. Government job, or any other position along the lines of his/her usual occupation. (If your answer to item "a" is "NO", you are ineligible for preference and need not submit this form

a. Are you presently married to the veteran? YES 301 NO 1010 — C and H

☐ 13. 295 PREFERENCE FOR WIDOW OR WIDOWER of a veteran. (If your answer is "NO" to item "a" or "YES" to item "b", you are ineligible for preference and need not submit this form

a. Were you married to the veteran when he or she died? 309 150

b. Have you remarried? (Do not count marriages that were annulled.) 305 548

A, D, E, and G (Submit G when applicable.)

☐ 14. 296 PREFERENCE FOR (NATURAL) MOTHER of a service-connected permanently and totally disabled, or deceased veteran provided you are or were married to the father of the veteran, and
--your husband (either the veteran's father or the husband of a remarriage) is totally and permanently disabled, or
--you are now widowed, divorced, or separated from the veteran's father and have not remarried, or
--you are widowed or divorced from the veteran's father and have remarried, but are now widowed, divorced, or separated from the husband of your remarriage.
(If your answer is "NO" to item "c" or "d", you are ineligible for preference and need not submit this form.)

a. Are you married? 300 1008

b. Are you separated? If "YES," do not complete "c." Go to "d." 302 1007

c. If married now, is your husband totally and permanently disabled? 306 971

d. If the veteran is dead, did he/she die in active service? 307 970

DISABLED VETERAN: C, F, and H (Submit F when applicable.)

DECEASED VETERAN: A, D, E, and F (Submit F when applicable.)

PRIVACY ACT STATEMENT

The Veterans' Preference Act of 1944 authorizes the collection of this informa- tion. The information will be used, along with any accompanying documentation, to determine whether you are entitled to 10-point veterans' preference. This information may be disclosed to: (1) the Veterans' Administration, or the appropriate branch of the Armed Forces to verify your claim; (2) a court, or a Federal, State, or local agency for checking on law violations or for other related authorized purposes; (3) a Federal, State, or local government agency, if you are participating in a special employment assistance program; or (4) other Federal, State, or local government agencies, congressional offices, and international organizations for purposes of employment consideration, e.g., if you are on an Office of Personnel Management list of eligibles.

Executive Order 9397 authorizes Federal agencies to use the Social Security Number (SSN) to identify individual records in Federal personnel records systems. Your SSN will be used to ensure accurate retention of records pertaining to you and may also be used to identify you to others from whom information about you is sought. Furnishing your SSN and the other information sought is voluntary. However, failure to provide any part of the information may result in a ruling that you are not eligible for 10-point veterans' preference or in delaying the processing of your application for employment.

I certify that all of the statements made in this claim are true, complete and correct to the best of my knowledge and belief and are made in good faith. [A false answer to any question may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001).]

This Form Must be Signed By All Persons Claiming 10-Point Preference

Signature of Person Claiming Preference 48

Date Signed (Month, Day, Year) 219

FOR USE BY APPOINTING OFFICER ONLY
Signature and Title of Appointing Officer 52, 55

310 ☐ Preference Entitlement Was Verified

Name of Agency 16

Date Signed (Month, Day, Year) 490

DOCUMENTATION REQUIRED -- READ CAREFULLY

(PLEASE SUBMIT PHOTOCOPIES OF DOCUMENTS BECAUSE THEY WILL NOT BE RETURNED)

A. DOCUMENTATION OF SERVICE AND SEPARATION UNDER HONORABLE CONDITIONS

Submit any of the documents listed below as documentation, provided they are dated on or after the day of separtation from active duty military service.

1. Honorable or general discharge certificate.
2. Certificate of transfer to Navy Fleet Reserve, Marine Corps Fleet Reserve, or Enlisted Reserve Corps.
3. Orders of Transfer to Retired List.
4. Report of Separation from a branch of the Armed Forces.
5. Certificate of Service or release from active duty, provided honorable separation is shown.
6. Official Statement from a branch of the Armed Forces showing that honorable separation took place.
7. Notation by the Veterans' Administration or a branch of the Armed Forces on official statement, described in B or C below, that the veteran was honorably separated from military service.
8. Official statement from the Military Personnel Records Center that official service records show that honorable separtion took place.

B. DOCUMENTATION OF SERVICE-CONNECTED DISABILITY (NON-COMPENSABLE, E.E., LESS THAN 10%); PURPLE HEART; AND NONSERVICE-CONNECTED DISABILITY PENSION

Submit one of the the following documents:

1. An official statement, dated within the last 12 months, from the Veterans' Administration or from a branch of the Armed Forces, certifying to the present existence of the veteran's service-connected disability of less than 10%.
2. An official citation, document, or discharge certificate, issued by a branch of the Armed Forces, showing the award to the veteran of the Purple Heart for wound or injuries received in action.
3. An official statement, dated within the last 12 months, from the Veterans' Administration, certifying that the veteran is receiving a nonservice-connected disability pension.

C. DOCUMENTATION OF SERVICE-CONNECTED DISABILITY (COMPENSA- BLE, I.E., 10% OR MORE)

Submit one of the following documents, if you checked Item 11 on the front of this form:

1. An official statement, dated within the last 12 months, from the Veterans' Administration or from a branch of the Armed Forces, certifying to the veteran's present receipt of compensation for service-connected disability or disability retired pay.
2. An official statement, dated within the last 12 months, from the Veterans' Administration or from a branch of the Armed Forces, certifying that the veteran has a service-connected disability of 10% or more.
3. An official statement or retirement orders from a branch of the Armed Forces, showing that the retired serviceman was retired because of permanent service-connected disability or was transferred to the permanent disability retirement list. The statement or retirement orders must indicated that the disability is 10% or more.

For Spouses and mothers of disabled veterans checking Items 12 or 14, submit the following:

An official statement, dated within the last 12 months, from the Veterans' Administration or from a branch of the Armed Forces, certifying: 1) the present existence of the veteran's service-connected disability, 2) the percentage and nature of the service-connected disability or disabilities (including the combined percentage), 3) a notation as to whether or not the veteran is currently rated as "unemployable" due to the service-connect- ed disability, and 4) a notation as to whether or not the service-connected disability is rated as permanent and total.

D. DOCUMENTATION OF VETERAN'S DEATH

1. If on active military duty at time of death, submit official notice, from a branch of the Armed Forces, of death occurring under honorable conditions.
2. If death occured while not on active military duty, submit death certificate.

E. DOCUMENTATION OF SERVICE OR DEATH DURING A WAR, IN A CAM- PAIGN OR EXPEDITION FOR WHICH A CAMPAIGN BADGE IS AUTHORIZED, OR DURING THE PERIOD OF APRIL 28, 1952, THROUGH JULY 1, 1955

Submit documentation of service or death during a war or during the period April 28, 1952, through July 1, 1955, or during a campaign or expedition for which a campagin badge is authorized.

F. DOCUMENTATION OF DECEASED OR DISABLED VETERAN'S MOTHER'S CLAIM FOR PREFERENCE BECAUSE OF HER HUSBAND'S TOTAL AND PERMANENT DISABILITY

Submit a statement from husband's physician showing the prognosis of his disease and percentage of his disability.

G. DOCUMENTATION OF ANNULMENT OF REMAIRRIAGE BY WIDOW OR WIDOWER OF VETERAN

Submit either:

1. Certification from the Veterans' Administration that entitlement to pension or compensation was restored due to annulment.
2. A certified copy of the court decree of annulment.

H. DOCUMENTATION OF VETERAN'S INABILITY TO WORK BECAUSE OF A SERVICE-CONNECTED DISABILITY

Answer questions 1-7 below:

1. Is the veteran currently working? If "NO", go to Item 3 308 ☐ YES ☐ NO 969

2. If currently working, what is the veteran's present occupation? 1050

3. What was the veteran's occupation, if any, before military service? 87

4. What was the veteran's military occupation at time of separation? 1052

5. Has the veteran been employed, or is he/she now employed, by the Federal civil service or D.C. Government? 304 ☐ YES ☐ NO 973

A. Title and Grade of Position Most Recently, or Currently, Held	B. Name and Address of Agency	C. Dates of Employment From	To
80, 114	998, 619, 5, 625, 16 or 32, 8	405	409

6. Has the veteran resigned from, been disqualified for, or separated from a position in the Federal civil service or D.C. Government along the lines of his/her usual occupation because of service-connected disability? If "YES", submit documentation of the resignation, disqualification, or separation. 303 ☐ YES ☐ NO 972

7. Is the veteran receiving a civil service retirement pension? If "YES", give the Civil Service or Federal Employee retirement annuity nur 263 ☐ YES ☐ NO 1149 CSA-- 1101

STANDARD FORM 15 (REV. 2/90) BACK

Standard Form 50-B
Rev. 7/91
U.S. Office of Personnel Mana
FPM Supp. 296-33, Subch. 4

146, 9

NOTIFICATION OF PERSONNEL ACTION

1. Name (Last, First, Middle): 77, 78, 79, 821
2. Social Security Number: 880
3. Date of Birth: 468
4. Effective Date: 212

FIRST ACTION

5-A. Code: 806
5-B. Nature of Action: 934
5-C. Code: 798
5-D. Legal Authority: 940
5-E. Code: 799
5-F. Legal Authority: 1078

SECOND ACTION

6-A. Code: 807
6-B. Nature of Action: 941
6-C. Code: 800
6-D. Legal Authority: 1079
6-E. Code: 801
6-F. Legal Authority: 1080

7. FROM: Position Title and Number: 87, 965

15. TO: Position Title and Number: 80, 966

8.Pay Plan	9. Occ. Code	10. Grade/Level	11. Step/Rate	12. Total Salary	13.Pay Basis
124	126	122	132	856	808

12A. Basic Pay	12B. Locality Adj.	12C. Adj. Basic Pay	12D. Other Pay
665	854	852	855

16.Pay Plan	17.Occ. Code	18. Grade/Level	19. Step/Rate	20. Salary/Award	21. Pay Basis
125	127	114	128	858	823

20A. Basic Pay	20B. Locality Adj.	20C. Adj. Basic Pay	20D. Other Pay
660	668	666	857

14. Name and Location of Position's Organization: 32, 41, 25

22. Name and Location of Position's Organization: 25

554 747

EMPLOYEE DATA

23. Veterans Preference: 813
1 - None 3 - 10-Point/Disability 5 - 10-Point/Other
2 - 5 Point 4 - 10-Point/Compensable 6 - 10-Point/Compensable/30%

24. Tenure: 811
0 - None 2 - Conditional
1 - Permanent 3 - Indefinite

25. Agency Use: 455 350

26. Veterans Preference for RIF: YES NO

27. FEGLI: 804 939

28. Annuitant Indicator: 630 937

29. Pay Rate Determinant: 809 576

30. Retirement Plan: 628 944

31. Service Comp. Date (Leave): 736

32. Work Schedule: 814 945

33. Part-Time Hours Per Biweekly Pay Period: 888

POSITION DATA

34. Position Occupied: 810
1 - Competitive Service 3 - SES General
2 - Excepted Service 4 - SES Career Reserved

35. FLSA Category: 805
E - Exempt
N - Nonexempt

36. Appropriation Code: 797

37. Bargaining Unit Status: 802

38. Duty Station Code: 803

39. Duty Station (City - County - State or Overseas Location): 938

40. Agency Data: 454
41. 936
42. 1075
43. 1076
44. 1077

45. Remarks: 942

46. Employing Department or Agency: 16

47. Agency Code: 629
48. Personnel Office ID: 69
49. Approval Date: 490

50. Signature/Authentication and Title of Approving Official: 52, 54, 55

TURN OVER FOR IMPORTANT INFORMATION
5-Part 50-316

Editions Prior To 7/91 Are Unusable After 6/30/93
NSN 7540-01-333-6238

Standard Form 52-B
Rev 7/91
U.S. Office of Personnel Management
FPM Supp. 296-33, Subch. 3

146, 9

REQUEST FOR PERSONNEL ACTION

PART A - Requesting Office (Also complete Part B, Items 1, 7-22, 32, 33, 36 and 39.)

1. Actions Requested: 946
2. Request Number: 1097
3. For Additional Information Call (Name and Telephone Number): 149, 106
4. Proposed Effective Date: 889
5. Action Requested By (Typed Name, Title, Signature, and Request Date): 148, 57, 83, 484
6. Action Authorized By (Typed Name, Title, Signature, and Concurrence Date): 54, 52, 55, 490

PART B - For Preparation of SF 50 (Use only codes in FPM Supplement 292-1. Show all dates in month-day-year order.)

1. Name (Last, First, Middle): 77, 78, 79, 821
2. Social Security Number: 880
3. Date of Birth: 468
4. Effective Date: 212

First Action

5-A. Code: 806 | 5-B. Nature of Action: 934
5-C. Code: 798 | 5-D. Legal Authority: 940
5-E. Code: 799 | 5-F. Legal Authority: 1078

Second Action

6-A. Code: 807 | 6-B. Nature of Action: 941
6-C. Code: 800 | 6-D. Legal Authority: 1079
6-E. Code: 801 | 6-F. Legal Authority: 1080

7. FROM: Position Title and Number: 965, 87

8. Pay Plan	9. Occ. Code	10. Grade or Level	11. Step or rate	12. Total Salary	13. Pay Basis
124	126	122	132	856	808

12A. Basic Pay	12B. Locality Adj.	12C. Adj. Basic Pay	12D. Other Pay
665	854	852	855

14. Name and Location of Position's Organization: 32, 25, 41

15. TO: Position Title and Number: 966, 80

16. Pay Plan	17. Occ. Code	18. Grade or Level	19. Step or rate	20. Total Salary/Award	21. Pay Basis
125	127	114	128	858	823

20A. Basic Pay	20B. Locality Adj.	20C. Adj. Basic Pay	20D. Other Pay
660	668	666	857

22. Name and Location of Position's Organization: 25

554 747

Employee Data

23. Veterans Preference: 813
1 - None; 2 - 5 Point; 3 - 10 Point/Disability; 4 - 10 Point/Compensable; 5 - 10 Point/Other; 6 - 10 Point/Compensable/30%

24. Tenure: 811
0 - None; 1 - Permanent; 2 - Conditional; 3 - Indefinite

25. Agency Use: 455 350

26. Veterans Preference for RIF: YES / NO

27. FEGLI: 804 939

28. Annuitant Indicator: 630 937

29. Pay Rate Determinant: 809

30. Retirement Plan: 628 944

31. Service Comp. Date (Leave): 736

32. Work Schedule: 814 945

33. Part-Time Hours Per Biweekly Pay Period: 888

Position Data

34. Position Occupied: 810
1 - Competitive Service; 2 - Excepted Service; 3 - SES General; 4 - SES Career

35. FLSA Category: 805
E - Exempt; N - Nonexempt

36. Appropriation Code: 797

37. Bargaining Unit Status: 802

38. Duty Station Code: 803

39. Duty Station (City - County - State or Overseas Location): 938

40. Agency Data: 454
41. 936
42. 1075
43. 1076
44. 1077

45. Educational Level: 817
46. Year Degree Attained: 692
47. Academic Discipline: 815
48. Functional Class: 818
49. Citizenship: 816 (1 - USA; 8 - Other)
50. Veterans Status: 820
51. Supervisory Status: 819

PART C - Reviews and Approvals (Not to be used by requesting office.)

1. Office/Function	Initials/Signature	Date	Office/Function	Initials/Signature	Date
A.			D.		
B.			E.		
C.			F.		

2. Approval: I certify that the information entered on this form is accurate and that the proposed action is in compliance with statutory and regulatory requirements.

Signature: 59

Approval Date: 500

CONTINUED ON REVERSE SIDE
52-306
OVER
Editions Prior to 7/91 Are Not Usable after 6/30/93
NSN 7540-01-333-6240

PART D - Remarks by Requesting Office

(Note to Supervisors: Do you know of additional or conflicting reasons for the employee's resignation/retirement? If "YES", please state these facts on a separate sheet and attach to SF 52.)

☐ YES ☐ NO

948 947 667

PART E - Employee Resignation/Retirement

Privacy Act Statement

You are requested to furnish a specific reason for your resignation or retirement and a forwarding address. Your reason may be considered in any future decision regarding your re-employment in the Federal service and may also be used to determine your eligibility for unemployment compensation benefits. Your forwarding address will be used primarily to mail you copies of any documents you should have or any pay or compensation to which you are entitled.

This information is requested under authority of sections 301, 3301, and 8506 of title 5, U.S. Code. Sections 301 and 3301 authorize OPM and agencies regulations with regard to employment of individuals in the Federal service and their records, while section 8506 requires agencies to furnish the specific reason for termination of Federal service to the Secretary of Labor or a State agency in connection with administration of unemployment compensation programs.

The furnishing of this information is voluntary; however, failure to provide it may result in your not receiving: (1) your copies of those documents you should have; (2) pay or other compensation due you; and (3) any unemployment compensation benefits to which you may be entitled.

1. Reason for Resignation/Retirement (NOTE: Your reasons are used in determining possible unemployment benefits. Please be specific and avoid generalizations. Your resignation/retirement is effective at the end of the day - midnight - unless you specify otherwise.)

949

2. Effective Date	3. Your Signature	3. Date Signed	4. Forwarding Address (Number, Street, City, State, ZIP Code)
220	48	219	74, 75, 1, 73, 17, 135

PART F - Remarks for SF 50

942

STANDARD FORM 59
Revised January 1979
Office of Personnel Management
296-33

REQUEST FOR APPROVAL OF NONCOMPETITIVE ACTION

IMPORTANT: See instructions on reverse and detailed instructions in Subchapters S4 and S5, Appendix A, FPM Supplement 296-31.

(Enter Name, Address, and ZIP Code of OPM Office)

Office of Personnel Management

ATTENTION:

1. Type of Action
- ☐ Transfer
- ☐ Position change
- ☐ Reinstatement
- ☐ Temporary or Term Appointment based on Reinstatement Eligibility
- ☐ Career Appointment
- ☐ Career Conditional Appointment
- ☐ Conversion to Career or Career-Conditional Appointment
- ☐ Appointment (Spec. Tenure)
- ☐ Excepted Appointment
- ☐ Detail
- ☐ Other *(Specify)*:

2. OPM Regulation or other authority under which action is requested:

3. Is employee now serving under a career or career conditional appointment: ☐ Yes ☐ No

Fold

4. Name *(Last, First, M.I.)*

5. Total length of service in present grade:

6. Home Address—Complete if employee is to take written test. *(Number, Street, City, State, and ZIP Code)*

7. Veteran Preference ☐ Yes ☐ No

8. Birth Date *(Month, Day, Year)*

9.	FROM	TO
A. Position Title Pay Plan Occupational Code Grade and Salary		
B. Bureau of Office		
C. Duty Station		

10. Have requirements other than those for which prior approval is requested been met? (Fill out in ALL cases) ☐ Yes ☐ No *(If "No," explain in Item 11, below.)*

11. Enter (or attach) any supporting statements required by instructions on this form or in FPM Supplement 296-31, Appendix A.

Fold

Attach description of duties of proposed position (except where title is descriptive of the duties, such as typist, stenographer, etc.)

12. Reason for Submission *(To be checked by agency.)*
- ☐ A. Prior approval of nominee's experience and training.
- ☐ B. Prior approval of action involved:
  - ☐ (1) Waiver of Time-After-Competitive-Appointment restriction under OPM Regulation 330.501.
  - ☐ (2) Waiver of experience and training requirement.
  - ☐ (3) Written test.

B *(Continued)*
  - ☐ (4) A position for which no experience and training standards have been issued.
  - ☐ (5) A person separated for cause.
  - ☐ (6) Extension of detail beyond 120 days.
  - ☐ (7) Other *(Specify)*:

(Enter Name, Address, and ZIP Code of Requesting Office)

For Information Call *(Name, Telephone No., including Area Code)*

Authorized Signature

Title	Date Signed *(Month, Day, Year)*

SEE OTHER SIDE FOR OPM ACTION ON THIS REQUEST

59-107

INSTRUCTIONS

NUMBER OF COPIES TO BE SUBMITTED

Submit this form in duplicate.

OFFICE TO WHICH REQUEST IS SUBMITTED

Submit this request to the office which has recruiting jurisdiction over the position involved, except when instructions applicable to the case (see Subchapters S4 and S5, Appendix A, FPM Supplement 296-31) require submission to the OPM's central office (for example, all requests for career appointment based on service in the legislative or judicial branch under section 2(b) or (c) of the Ramspeck Act are submitted to the Staffing Systems and Services Group, Office of Personnel Management, Washington, D.C. 20415).

SUPPORTING DOCUMENTS AND STATEMENTS

Attach to all requests a completed copy of Standard Form 171 (or 173), Personal Qualifications Statement: except that Standard Form 172, Amendment to Personal Qualifications Statement, may be used with requests which involve qualification requirements only. (Standard Form 172 may be omitted when the administration of a written test is the only action involved.) Attach any additional documents and include in Item 11 (or attach) any statements required by applicable instructions in Subchapter S4 or S5, Appendix A, FPM Supplement 296-31.

REQUEST INVOLVING SEPARATION FOR CAUSE

State whether the nominee's Official Personnel Folder is in the agency's possession, or has been requested by it.

OPM ACTION

The action proposed on the reverse side of this form is: ☐ Approved ☐ Disapproved *(See note below.)*

The requirements which are checked below were reviewed in making this decision:

☐ Qualifications requirements only
☐ Suitability
☐ Reinstatement eligibility determination
☐ Other *(Specify under "Remarks")*

Note: The agency must determine whether the individual meets all other requirements for the action proposed.

Remarks:

OFFICE OF PERSONNEL MANAGEMENT	Authorized Signature	Date *(Month, Day, Year)*

☆ U.S. Government Printing Office: 1987—201-760/60220

STANDARD FORM 61
Revised June 1986

U.S. Office of Personnel Management
FPM Chapter 296
61-108

146, 9

APPOINTMENT AFFIDAVITS

80 (Position to which appointed) 221 (Date of appointment)

16 (Department or agency) (Bureau or Division) 25 (Place of employment)

I, 77, 78, 79, 821, do solemnly swear (or affirm) that--

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration of or in expectation or hope of receiving assistance in securing this appointment.

48 (Signature of appointee)

Subscribed and sworn (or affirmed) before me this 884 day of 885 19 , 886

at 998 (City) 619 (State)

186 [SEAL]

52 (Signature of officer)

Commission expires 883 (If by a Notary Pubic, the date of expiration of his/her Commission should be shown)

55 (Title)

NOTE. The oath of office must be administered by a person specified in 5 U.S.C. 2903. The words "So help me God" in the oath and the word "swear" wherever it appears above should be stricken out when the appointee elects to affirm rather than swear to the affidavits; only these words may be striken and only when the appointee elects to affirm the affidavits.

NSN 7540-00-634-4015 Prior Edition Usable

NSN7540-00-634-4063 *SF-127 Date* [146, 9]

REQUEST FOR PERSONNNEL FOLDER

(SEPERATED EMPLOYEE)

1. DATE OF REQUEST [484]

SECTION I - TO BE COMPLETED BY REQUESTING PERSONNEL OFFICE

2. CURRENT NAME - (Last, first, middle)
[77, 78, 79, 821]

2a. NAME UNDER WHICH FORMERLY EMPLOYED FEDERALLY (if different than Item 2)
[1152, 162, 1153, 1154]

3. DATE OF BIRTH
[468]

4. SOCIAL SECURITY NUMBER
[880]

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
NATIONAL PERSONNEL RECORDS CENTER
(Civilian Personnel Records)
111 WINNEBAGO STREET
ST. LOUIS, MO 63118

SUBMIT IN DUPLICATE FOR EACH FOLDER REQUESTED

Original will be used to send folder or reply to your agency.
Second copy retained by agency for its suspense files.
Third copy is for records center use.

5. PREVIOUS FEDERAL EMPLOYMENT

AGENCY AND BUREAU	LOCATION	FROM	TO
[32]	[8]	[405]	[409]

6. REASON FOR REQUEST (Check appropriate box)

❑ a. Currently employed [286] ❑ b. Temporary use. [287] ❑ c. Pre-employment consideration. Will retain folder If hired. [288]

REMARKS
[931]

SECTION II - FOR USE BY RECORDS CENTER

[289]❑ a. Folder enclosed

[290]❑ b. Our search did not reveal a record of claimed civilian Federal employment. Please submit any additional information or documentation that will help verify this employment.

[291]❑ c. Folder not received. Suggest you contact last employing office.

[292]❑ d. Folder not located. For a former employee of your agency, we suggest a further search f your agency. If still unlocated, verify name, date of birth, and social security number, and return request to NPRC together with the date folder was transferred to NPRC and several names, dates of birth, and social security numbers of other folders in same shipment.

[1132] ❑ a. Folder was sent (Date) [510]

To: [1043]

❑ Your agency [293]

❑ f. Other [1133, 1044]

DATE [489] INITIALS [56]

SECTION III - TO BE COMPLETED BY REQUESTING PERSONNEL OFFICE

NAME OF REQUESTER [148] TELEPHONE NO. [109]

[14] Requesting Agency

[469] Requesting Agency Address

Enter complete address to which folder or reply is to be mailed. Include ZIP Code:

Standard Form 144 (Rev. 10/95) Page 2
Office of Personnel Management
The Guide to Processing Personnel Actions

STATEMENT OF PRIOR FEDERAL SERVICE

To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
☐ Yes — If "Yes", check this block and skip to Item 8. ☐ No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
☐ Yes — If "Yes", list the following information. ☐ No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?
☐ No ☐ Yes — Check one of the statements, if it applies to you. I claim preference as the:
☐ Spouse of a disabled veteran ☐ Mother of a deceased or disabled veteran ☐ Unmarried widow/widower of a veteran

9. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date

NSN 7540-00-634-4101 Previous Edition Usable 144-114
*U.S. Government Printing Office: 1996 - 404-761/32401

Standard Form 144A **[146]** (10/95) **[9]**
Office of Personnel Management
The Guide to Processing Personnel Actions

STATEMENT OF PRIOR FEDERAL SERVICE - - WORKSHEET

Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (Month, Day, Year)
[77, 78, 79, 821]	**[880]**	**[468]**

INSTRUCTIONS: Enter the appointment and separation dates in columns (A) and (B) below, using the numerical equivalent of the month. See Chapter 6 of *The Guide to Processing Personnel Actions* for instructions on computing service computation dates (SCDs).

PART I - CREDITABLE SERVICE AND SERVICE COMPUTATION DATE FOR LEAVE PURPOSES

CREDITABLE SERVICE - NAME OF AGENCY/ORGANIZATION (List only periods that are creditable for leave purposes)	(A) APPOINTMENT DATE			(B) SEPARATION DATE			NONCREDITABLE SERVICE (Explain noncreditable time listed in Column (A), such as "lost time" during military service)
	Year	Month	Day	Year	Month	Day	
[33]	**[405]** **[203]**			**[409]** **[204]**			**[1098]**
Entrance of Duty Date	**[399]**						
Total noncreditable service	**[737]**						
Total of appointment dates (A)	**[739]**						
Total of separation dates (B)				**[741]**			
SCD - Leave (A) - (B)	**[736]**						

PART II - CREDITABLE SERVICE AND SERVICE COMPUTATION DATE FOR REDUCTION-IN-FORCE (RIF) PURPOSES
Complete only in cases where the amount of service that is creditable for RIF purposes differs from the amount creditable for leave purposes,

CREDITABLE SERVICE - NAME OF AGENCY/ORGANIZATION	(A) APPOINTMENT DATE			(B) SEPARATION DATE			NONCREDITABLE SERVICE (Explain noncreditable time listed in Column (A), such as "lost time" during military service)
	Year	Month	Day	Year	Month	Day	
SCD - Leave (from Part I) **[736]** Additional service creditable for RIF only **[34]**	**[10]**			**[11]**			**[1049]**
Total noncreditable service	**[738]**						
Total of appointment dates (A)	**[740]**						
Total of separation dates (B)				**[742]**			
SCD - RIF (Service Date) (A) - (B)	**[706]**						

REMARKS
[931]

Name of Person Computing SCD(s0	Date SCD(s) Computed
[149]	**[501]**

CLASSIFIED INFORMATION NONDISCLOSURE AGREEMENT

AN AGREEMENT BETWEEN **[78, 79, 77, 821]** AND THE UNITED STATES

1. Intending to be legally bound, I hereby accept the obligations contained in this agreement in consideration of my being granted access to classified information. As used in this Agreement, classified information is marked or unmarked classified information, including oral communications, that is classified under the standards of Executive Order 12356, or under any other Executive order or statute that prohibits the unauthorized disclosure of information in the interest of national security; and unclassified information that meets the standards for classification and is in the process of a classification determination as provided in Sections 1.1 and 1.2(e) of Executive Order 12356, or under any other Executive order or statute that requires protection for such information in the interest of national security. I understand and accept that by being granted access to classified information, special confidence and trust shall be placed in me by the United States Government.

2. I hereby acknowledge that I have received a security indoctrination concerning the nature and protection of classified information, including the procedures to be followed in ascertaining whether other persons to whom I contemplate disclosing this information have been approved for access to it, and that I understand these procedures.

3. I have been advised that the unauthorized disclosure, unauthorized retention, or negligent handling of classified information by me could cause damage or irreparable injury to the United States or could be used to advantage by a foreign nation. I hereby agree that I will never divulge classified information to anyone unless: (a) I have officially verified that the recipient has been properly authorized by the United States Government to receive it; or (b) I have been given prior written notice of authorization from the United States Government Department or Agency (hereinafter Department or Agency) responsible for the classification of the information or last granting em a security clearance that such disclosure is permitted. I understand that if I am uncertain about the classification status of information, I am required to confirm from an authorized official that the information is unclassified before I may disclose it, except to a person as provided in (a) or (b), above. I further understand that I am obligated to comply with laws and regulations that prohibit the unauthorized disclosure of classified information.

4. I have been advised that any breach of this Agreement may result in the termination of any security clearances I hold; removal from any position of special confidence and trust requiring such clearances; or the termination of my employment or other relationships with the Departments or Agencies that granted my security clearance or clearances. In addition, I have been advised that any unauthorized disclosure of classified information by me may constitute a violation, or violations, of United States criminal laws, including the provisions of Sections 641, 793, 794, 798, and *952, Title 18, United States Code, *the provisions of Section 783(b), Title 50, United States Code, and the provisions of the Intelligence Identities Protection Act of 1982. I recognize that nothing in this Agreement constitutes a waiver by the United States of the right to prosecute me for any statutory violation.

5. I hereby assign to the United States Government all royalties, remunerations, and emoluments that have resulted, will result or may result from any disclosure, publication, or revelation of classified information not consistent with the terms of this Agreement.

6. I understand that the United States Government may seek any remedy available to it to enforce this Agreement, including, but not limited to, application for a court order prohibiting disclosure of information in breach of this Agreement.

7. I understand that all classified information to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of the United States Government unless and until otherwise determined by an authorized official or final ruling of a court of law. I agree that I shall return all classified materials which have, or may come into my possession or for which I am responsible because of such access: (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me a security clearance or that provided me access to classified information; r (c) upon the conclusion of my employment or other relationship that requires access to classified information. If I do not return such materials upon request, I understand that this may be a violation of Section 793, Title 18, United States Code, a United States criminal law.

8. Unless and until I am released in writing by an authorized representative of the United States Government, I understand that all conditions and obligations imposed upon me by this Agreement apply during the time I am granted access to classified information, and at all times thereafter.

9. Each provision of this Agreement is severable. If a court should find any provision of this Agreement to be unenforceable, all other provisions of this Agreement shall remain in full force and effect.

10. These restrictions are consistent with and do not supersede, conflict with or otherwise alter the employee obligations, rights or liabilities created by Executive order 12356; Section 7211 of Title 5, United States Code (governing disclosures to Congress); Section 1034 of Title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); Section 2302(b)(8) of Title 5, United States Code, as amended by the Whistleblower Protection Act (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents), and the statutes which protect against disclosure that may compromise the national security, including Sections 641, 793, 794, 798, and 952 of Title 18, United States Code, and Section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. Section 783(b)). The definitions, requirements, obligations, rights, sanctions and liabilities created by said Executive Order and listed statutes are incorporated into this Agreement and are controlling.

(Continue on reverse.)

11. I have read this Agreement carefully and my questions, if any, have been answered. I acknowledge that the briefing officer has made available to me the Executive Order and statutes referenced in this Agreement and its implementing regulation (32 CFR Section 2003.20) so that I may read them at this time, if I so choose.

SIGNATURE	DATE	SOCIAL SECURITY NUMBER (See Notice below)
[48]	**[219]**	**[880]**

ORGANIZATION (IF CONTRACTOR, LICENSEE, GRANTEE OR AGENT, PROVIDE: NAME, ADDRESS, AND, IF APPLICABLE, FEDERAL SUPPLY CODE NUMBER)

[16, 998, 619, 5, 625]

WITNESS		**ACCEPTANCE**	
THE EXECUTION OF THIS AGREEMENT WAS WITNESSED BY THE UNDERSIGNED.		THE UNDERSIGNED ACCEPTED THIS AGREEMENT ON BEHALF OF THE UNITED STATES GOVERNMENT.	
SIGNATURE **[64]**	DATE **[905]**	SIGNATURE **[52]**	DATE **[490]**
NAME AND ADDRESS (Type or print) **[174, 645, 646]**		NAME AND ADDRESS (Type or print) **[54, 470]**	

SECURITY DEBRIEFING ACKNOWLEDGEMENT

I reaffirm that the provisions of the espionage laws, other federal criminal laws and executive orders applicable to the safeguarding of classified information have been made available tome; that I have returned all classified information in my custody; that I will not communicate or transmit classified information to any unauthorized person or organization; that I will promptly report to the Federal Bureau of Investigation any attempt by an unauthorized person to solicit classified information, and that I (have) (have not) (strike out inappropriate word or words) received a security debriefing.

SIGNATURE OF EMPLOYEE	DATE
[161]	**[183]**
NAME OF WITNESS (Type or print)	SIGNATURE OF WITNESS
[175]	**[65]**

NOTICE: The Privacy Act, 5 U.S.C. 552a, requires that federal agencies inform individuals, at the time information is solicited from them, whether the disclosure is mandatory or voluntary, by what authority such information is solicited, and what uses will be made of the information. You are hereby advised that authority for soliciting your Social Security Account Number (SSN) is Executive Order 9397. Your SSN will be used to identify you precisely when it is necessary to 1) certify that you have access to the information indicated above or 2) determine that your access to the information indicated has terminated. Although disclosure of your SSN is not mandatory, your failure to do so may impede the processing of such certifications or determinations, or possibly result in the denial of your being granted access to classified information.

NOT APPLICABLE TO NON-GOVERNMENT PERSONNEL SIGNING THIS AGREEMENT.

SF 813 (8/94) [146, 9]
U. S. Office of Personnel Management
FPM Supplement 296-33

Verification of a Military Retiree's Service In Nonwartime Campaigns or Expeditions

(See Instructions on Reverse Before Completing Form

Date of Request (Month, Day, Year
[484]

To: *(Address A or B from Reverse Side)*
[655]

PRIVACY ACT STATEMENT
Solicitation of this information is authorized by sections 3502, "Retention Order, and 6303, "Leave Accrual," of Title 5, United States Code, and solicitation of the Social Security Number (SSN) is authorized by Executive Order 9397, "Using Social Security Number as Identifier." This information, including SSN, will be used to verify periods of creditable service in all campaigns and expeditions claimed. Furnishing this information, including the SSN is voluntary, but failure to comply may make it difficult or impossible to verify periods of creditable service.

1. Name Used During Military Service	2. Service Number	3. Social Security Number
[77, 78, 79, 821 or 1152, 1153, 1154]	[746]	[880]
4. Branch of Service	5. Date of Military Retirement	6. Last Military Rank Held
[35]	[464]	[0]

7. Remarks
[931]

8. NONWARTIME CAMPAIGNS AND EXPEDITIONS Service from 12/7/41 through 4/28/62 is always creditable and need not be verified	SERVICE CLAIMED						FOR RECORDS CENTER USE ONLY						
							If correct, check here	If not correct, give the dates (from and to) of the active duty the person performed in the period covered by the campaign badge or medal.					
	From:			To:				From:			To:		
	Mo.	Day	Yr.	Mo.	Day	Yr.		Mo.	Day	Yr.	Mo.	Day	Yr.
[954]		[465]			[466]		[598]		[1140]			[476]	

8. Requesting Agency *(Name, Address and Zip Code)*
[14, 469]

Items checked were verified by our records. Items which do not correspond with dates shown in records have been corrected.

Typed or Stamped Name and Title of Certifying Officer
[54, 55]

Signature
[52]

Date Signed
[490]

AUTHORIZED FOR LOCAL REPRODUCTION 813-101 Previously known as OPM Form 813

RECORD OF LEAVE DATA

1. Name (Last, First, Middle)	2. Social Security Number	3. (For agency use)
4. Date and Nature of Separation	5. A. Subject to 5 U.S.C. 6304(B) (45 day leave ceiling) Yes / No B. Last Date Subject to 5 U.S.C. 6304(B)	C. Annual Leave Balance as of That Date (Hours)

6. Total Service for Leave (as of Date of Separation)	More than 15 Years		
	Less Than 15 Years (show) Years	Months	Days

SUMMARY OF ANNUAL AND SICK LEAVE

	MO.	DAY	YEAR	HOURS Annual	Sick	Restored
7. Carryover Balance From Prior Leave Year Ending						
8. Current Leave Year Accrual Through Pay Period Ending (if 90 day restriction applicable, explain in remarks)						
9. Total						
10. Reduction in Credits, If Any (current year)						
11. Total Leave Taken, Current Year Through Date of Separation						
12. Balance						
13. Total Hours Paid in Lump Sum (includes ______ hours for holidays)						
14. Salary Rate(s) Per Hour:						

15.		MO.	DAY	YEAR	HOURS
Lump Sum Leave Dates (if part-time tour, explain in Remarks)	From				
	Thru				
a. Restored	From				
	Thru				
b. Annual Leave Above Ceiling	From				
	Thru				
c. Annual Leave Within Ceiling	From				
	Thru				

ABSENCE WITHOUT PAY

16. During Leave Year in Which Separated				Hours
17. A. Date of Last Equivalent Increase	MO.	DAY	YEAR	
B. Total AWOP Hours Since Last Equivalent Increase (except during military service and while in receipt of OWCP payments)				Hours

SUMMARY OF HOME LEAVE

18. Basic Service Period of 24 Months of Continuous Service Abroad:		MO.	DAY	YEAR
	Date Started			
	Date Completed			
19. Current 12 Months Accrual Period Began on		MO.	DAY	YEAR
Hours Absent Without Pay Since That Date →				
20. Current Balance (or accrual) as of		MO.	DAY	YEAR
Number of Days →				
21. Twelve Months Accrual Date as of Date of Separation Number of Days →				

22. Dates Leave Used Prior 24 Months	FROM MO.	DAY	YEAR	TO MO.	DAY	YEAR

MILITARY LEAVE 23. During Current Calendar Year	FROM MO.	DAY	YEAR	TO MO.	DAY	YEAR
A. Regular—Active Duty or Training						
B. Special—Civil Disturbance						

24. Remarks (include shore leave information, if applicable):

25. Certified Correct By: (Signature)	26. Title, Agency, Address, Telephone Number	27. Date

☆ GPO : 1978 O—260-455/32

STANDARD FORM 1150 (REV. 12-77)
CIVIL SERVICE COMMISSION
FPM SUPP. 296-31 AND 990-2

Standard Form 1150-A **[146]**

June 1989 **[9]**

U. S. Office of Personnel Management

FPM Chapter 630

Transfer Of Leave Records for Leave Recipient Covered By the Voluntary Leave Transfer Program (Addendum to SF 1150)

Instructions:

If the employee at the time of his or her separation is a current leave recipient under the Voluntary Leave Transfer Program (authorized by Public Law 100-566) and is transferring to another Federal agency without a break in service, the employing agency from which the employee is transferring must complete this form (SF 1150-A) and attach it to the SF 1150, Record of Leave Data. Both the SF 1150 and SF 1150-A must be forwarded to the employing agency to which the employee is transferring.

TO BE COMPLETED BY TRANSFERRING AGENCY

1. Name of Current Leave Recipient *(Last, First, Middle)*
[77, 78, 79, 821]

2. Social Security Number
[880]

3. Date Medical Emergency Began
[392]

4. Date Medical Emergency Terminated *(if applicable)*
[393]

5. Date Employee was Approved to Become a Leave Recipient
[500]

6. Effective Date of Separation (Transfer)
[220]

7. Total Hours of Annual Leave Donated to Leave Recipient as of the Date of Separation
[730]

8. Total Hours of Donated Annual Leave Used by the Leave Recipient as of the Date of Separation
[731]

9. Total Hours of Unused Donated Annual Leave as of the Date of Separation
[732]

10. Remarks *(Provide a list of all employees who donated annual leave to the leave recipient, including the total amount of annual leave donated by each employee.)*
[931]

11. Individual's Name Who Can Provide Further Information
[149]

Telephone Number
[106]

12. Authorizing Official's Name, Title, and Signature
[54, 55, 52]

Date Signed
[490]

REPRODUCE LOCALLY

CERTIFIED SUMMARY OF FEDERAL SERVICE
CIVIL SERVICE RETIREMENT SYSTEM

U.S. Office of Personnel Management

Information for Agency

1. A certified copy of this form must accompany the employee's application for Immediate Retirement (SF 2801) or an Application for Death Benefits (SF 2800) for a deceased employee if a survivor annuity appears to be payable.

2. This form may also be used:
   * for retirement counseling purposes
   * to respond to an employee's request for a record of creditable service.

3. See FPM Supplement 830-1 for detailed instructions for completion and disposition of this form.

Instructions for the Employee

1. Your employing office will complete and certify this form for you.

2. Review this form carefully. Be sure it contains all of your service.

3. Complete Section E, Employee's Certification, and return it to your employing office.

Section A - Identification

1. Name of employee (Last, first, middle initial) 77, 78, 79, 821	2. Date of birth (Month, day, yea 468	3. Social Security Number 880
4. List all other names used (Maiden name, AKA, spelling variants) 1152, 162, 1153, 1154	5. Other birth dates used 134	6. Military Serial Number 746
	7. Service computation date for retirement purposes 882	
8a. Does the applicant receive military retired pay? ☐ YES 546 y of the applicant's military retired pay order, if available e 8b. ☐ NO 1014	8b. If YES, has the application waived military retired pay to credit military service for civil service retirement? ☐ YES 547 y of the military finance center's letter to the employee iver, if available ☐ NO (1091 where a waiver is unnecessary)	

Section B - Verified Service History Documented In Official Records

Federal Agency or Military Service Branch	Appointment, Separation, or Conversion Dates for Civilian and Active Honorable Military Service		Name of Retirement System* (e.g., CSRS, CSRS Offset, etc.)	Remarks and Non-Creditable Time (Indicate if service is Part-time)
	From	To		
32, 35, 16	405, 203	409, 204	944	931, 394, 395, or 733, 734, 735 or 713

* Give details of creditable civilian service not subject to retirement deductions in Section C.

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Section C - Details of Civilian Service Not Subject to Contributory Retirement System for Civilian Federal Employees

This information is required to compute the portion of annuity based on such service.

Detail below (1) any period of Federal civilian service subject to "FICA" deductions, and (2) any other Federal civilian service not subject to a Federal employee (or D.C. Government) retirement system. If total basic salary earned for any such period of service is known, a summary entry may be entered on the right hand side below. Otherwise, show each change affecting basic salary during the period of service. Show part-time tour of duty if applicable. If part-time service is after April 6, 1986, also provide total number of hours employee worked during that period and show what a full-time tour of duty would be.

Nature of Action (Appt., pro, res., etc.)	Effective Date (Month, day, year)	Basic Salary Rate	Salary Basis (per annum, per hour, WAE, etc.)	Leave Without Pay	If Basic Salary Actually Earned is Available Make Summary Entry below		
					From (Month, day, year)	To (Month, day, year)	Total Earned
934	431	660	963	881	429	430	676

Section D - Agency Certification

I certify that the information in this form accurately reflects certified information contained on the official personnel and/or payroll records in the custody of this agency and that if retiring, the retiring employee has sufficient service to support title to an immediate annuity.

Signature of Authorized Agency Personnel Official 52

Agency Name and Address, including ZIP Code, and Telephone Number, including Area Code 16, 998, 619, 5, 625, 108

Official Title 55

Date 490

Section E - Employee's Certification

543

☐ **The above service is complete.**

☐ I have additional service. (If you claim additional service, attach signed statement(s) giving dates, positions, titles and locations of employment, including agency, bureau, and division. Claimed service cannot be credited for retirement until it has been verified, including unverified service listed on a SF 144, Statement of Prior Federal Civilian and Military Service, or similar affidavit.)

544

If you have performed Federal civilian service subject to social security deductions (FICA) or not subject to retirement deductions, be sure that your agency has correctly completed Section C above.

If you have active military service on or after January 1, 1957, for which you have not made a deposit, be sure to read Section B of the "Instructions for Completing Application for Immediate Retirement" for information on how this decision affects your annuity. You CANNOT change your decision after you retire.

Signature 48

Date 219

HEALTH BENEFITS REGISTRATION FORM

Federal Employees Health Benefits Program

Form Approved:
OMB No.
3206-0160
NSA Form in Delrina Apr 97

- Complete Part A and Parts B, C, D, and E as applicable.
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Type or Print Firmly.
- Sign and date in

PART A - *Fill in this part.*

1. Name *(Last, first, middle initial)*	2. Social Security number	3. Date of birth *(mo., day, yr.)*
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number	

PART B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan	Enrollment code			

2a. Names of family members	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security number *(See instructions)*

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ No ☐ Yes ⟶ Complete 3b

3b. Type of insurance ▶ Medicare ☐ No ☐ Yes ⟶ *Indicate part(s)* ☐ CHAMPUS ☐ Other private *(specify name)*

PART C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name	2. Present Plan enrollment code ▶				3. Number of event that permits change *(See Table of Permissable Changes)*		4. Date of event that permits change (mo., day, yr.)

PART D - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART F certifies that I have read and understand the information regarding this election.

PART E - *CANCELLATION*

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

Present Plan enrollment code

My signature in PART F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(Do not print)*	2. Date

PART G - *To be completed by agency*

1. Name and address of employing office	2. Date received in employing office	3. Effective date of action	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number	
	7. Personnel contact and telephone number		
	8. Signature of authorized agency official		9. Phone number

Remarks

EMPLOYEE SERVICE STATEMENT

(See information on reverse)

1. NAME *(CAPS)* LAST-FIRST-MIDDLE MR-MISS-MRS.	2. BIRTHDATE *(Mo., Day, Yr.)*	3. SOC. SEC. NUMBER	4. STATEMENT NO.
[77,78,79,821]	[468]	[880]	[1097]

5. SERVICE SUMMARY	FROM			TO			SERVICE			CIVIL SERVICE RETIREMENT DEDUCTIONS		IF "NO" NAME OTHER RETIREMENT SYSTEM
	MO.	DAY	YR.	MO.	DAY	YR.	YRS.	MOS.	DAYS	YES	NO	
A. PREVIOUS CIVILIAN SERVICE							[793]	[791]	[792]			
B. SERVICE PERFORMED IN THIS AGENCY	[399]			[220]			[796]	[794]	[795]	[340]	[1094]	[341]
C. MILITARY SERVICE	[203]			[204]			[790]	[788]	[789]			
D. ACCUMULATE ALL SERVICE AND ENTER TOTAL SERVICE HERE→							[787]	[785]	[786]			

6. COMPLETE THIS ITEM ONLY FOR EMPLOYEES SEPARATING FROM POSITIONS SUBJECT TO THE CIVIL SERVICE RETIREMENT SYSTEM - YOUR RETIREMENT BENEFIT, BASED ON THE ABOVE SEPARATION, IS INDICATED BELOW:

- ❑ [339] NONE - TRANSFER TO ANOTHER POSITION SUBFECT TO CSC RETIREMENT
- ❑ [338] LUMP SUM REFUND ONLY
- ❑ [336] DEFERRED ANNUITY AT AGE 62 OR LUMP SUM REFUND
- ❑ [337] IMMEDIATE ANNUITY

7. REMARKS CONCERNING SERVICE ENTRIES ABOVE:

[931]

8. SIGNATURE OF EMPLOYEE	DATE	11. AGENCY NAME, INCLUDING BUREAU AND DIVISION, AND ADDRESS
[48]	[219]	[16,998,619,5,625]
9. SIGNATURE OF AGENCY OFFICIAL	DATE	
[52]	[490]	
10. TITLE OF AGENCY OFFICIAL		
[55]		

2815 - 101

[146] **STANDARD FORM 2815**

[9]- MARCH 1974
FPM SUPPLEMENT
831-1

3. Official Personnel Folder Copy – Completion Instructions on Reverse

FEGLI
Federal Employees
Group Life Insurance

LIFE INSURANCE ELECTION

Federal Employees' Group Life Insurance Program

See Privacy Act Information on Back of Part 3

1 General Instructions: By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic Life insurance. When you first become eligible for FEGLI, you have the choice of (1) electing Basic Life and any or all of the options, (2) electing Basic Life but declining all of the options, or (3) waiving all life insurance coverage. If you are changing your election, see the back of Part 3 - Employee Copy.This election will supersede all previous elections. Type or print in ink.

Read the back of Part 3 - Employee Copy carefully. Assignees completing this form should be sure to read item 5 and 6 on the back of Part 3.
Do not separate the parts. Your employing office will complete the form and return your copy to you. This form should be kept with your FEGLI booklet, Description and Certification of Enrollment (RI 76-21 or RI 76-20 for Postal Service Employees).

2 Fill in identifying information concerning the insured

Name (Last) (First) (Middle)	Date of Birth (Month, Day, Year)	Social Security Number
77, 78, 79, 821	468	880
Employing Department or Agency	Agency Location (City, State, ZIP Code)	
16	998, 619, 625	

3 To elect Basic Life, sign and date below. If you do not elect Basic Life, you may not elect any form of optional insurance. If you do not **want any insurance at all, skip to section 5.**

Basic Life

I want the Basic Life insurance. I authorize deductions to pay my share of the cost.

Signature (Do not printOnly the insured/Assigee may sign. Signatu 517 s, conservators or through a power of attorney are not acceptable)

Date (Mo, Dy, Yr) 419

4 **If you have elected Basic Life, you may elect any or all of the following options (Unless you have prevously declined any or all of these** options, in which case you may only elect those options which you are eligible to elect as outlined in the FEGLI booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you decline one or more of the options, your opportunities to enroll in an option or increase your optional coverage are strictly limited. See "Conditions for Changing Election" in your FEGLI boolket. You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).

Option A - Standard	Option B - Additional	Option C - Family
I want the Standard optional insurance. I authorize deductions to pay the full cost.	I want the Additional optional insurance in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost. (Indicate multiple by marking "X" in the appropriat box. Do not mark more than one box.)	**I want the Family optional insurance. I** understand upon the death of my spouse I would receive $5,000 and upon the death **of an eligible child I would receive $2,500. I** authorize deductions to pay the full cost.
515	342 1 times my pay; 343 2 times my pay; 344 3 times my pay; 4 times my pay; 5 times my pay	345; 346; 518
Signature (Do not print. Only the insured/Assigee may sign. Signatures by guardians, conservators or through a power of attorney are not accept	Signature (516 nly the insured/Assigee may sign. S ardians, conservators or through a power of attorney are not acc	Signature (Do not print. Only the insured/Assigee may sign. Signatures by guardians, conservators or through a power of attorney are not
Date (mo, dy, yr) 417	Date (mo, dy, yr) 418	Date (mo, dy, yr) 420

5 **If you want NO life insurance coverage at all, sign and date below.**

Waiver of All Life Insurance Coverage

I want no insurance coverage at all. I understand that any insurance I have will stop at the end of the pay period in which my employing office receives this waiver and that I cannot get Basic Life insurance unless (1) I wait at least one year after I sign this form AND give satisfactory medical evidence of insurability, or (2) I have a break in Federal service of at least 180 days. I understand that I cannot get any optional insurance unless I first have Basic Life. I have read "Waiving or Changing Your Insurance Coverage" on the back of Part 3 and I understand that my decision to waive insurance coverage now may affect my eligibility for coverage as a retiree.

Signature (Do not print. Only the insured/Assigee may sign. Signature 519 , conservators or through a power of attorney are not acceptable.)

Date (Month, Day, Year) 421

6 To be completed by agency. Remarks: 931

Number of event permitting change → (See table on the back on Part 2) 624

Name and address of employing office 16, 470

Date received in employing office (Mo, Dy, Yr) 499

Effective date of coverage(Mo, Dy, Yr) 212

I followed the instructions on the back of Part 1.

Signature of Authorized Agency Official 52

The employee's copy of this form, when certified by the employing office, together with the FEGLI booklet, The Federal Employees' Group Life Insurance Program Descriptiona and Certification of Enrollment (RI 76-21), constitute the employee's Certi 146, 9 rance.

PART 1 - File in Official Personnel Folder

Notice of Conversion Privilege
Federal Employees' Group Life Insurance Program

Part A - Instructions to Employing Agency

Complete Part A of this form whenever an employee's life insurance coverage terminates due to separation, resignation, retirement, death or end of 12 months in non-pay status. On the date insurance terminates (except by waiver), give this notice to every employee and/or the assignee(s), if applicable, and to the family of each deceased employee who had the Option C-Family coverage. Also, upon request, give this notice to the family of an eligible employee who does not convert his or her Option C-Family insurance.
If this notice is prepared for a retiring employee, forward Part 2 (duplicate) to OPM with the employee's retirement papers. Otherwise, place Part 2 (duplicate) in the employee's Official Personnel Folder.

1. Name of employee	2. Date of birth *(mo., day, yr.)*	3. Date insurance terminated

4. Was employee insured for Option C-Family insurance on date in item 3?		Yes		No

Agency Certification ***I certify that the above information has been obtained from, and correctly reflects, official personnel records.***

5. Signature of authorized agency official		6. Name and mailing address of agency
7. Typed name of authorized agency official		
8. Title		
9. Telephone number	10. Date of this notice *(mo., day, yr.)*	

Part B - Conversion Information for Employees, Assignees, and Family Members Who are Losing FEGLI Coverage

If you are eligible and you will be carrying all of your Federal Employees' Group Life Insurance (FEGLI) coverage into retirement, do not apply for conversion. Employees (and assignees, if applicable) and their family members who are losing FEGLI coverage, however, may be eligible and wish to convert some or all of their coverage to an individual direct-pay policy.

Employees - If you have not assigned your FEGLI coverage, you are entitled to convert to an individual direct-pay policy unless, within 3 calendar days after the date your insurance terminates, you return to a Government position that qualifies you to reacquire FEGLI coverage. You may purchase an individual policy in an amount equal to or less than your Basic life insurance plus any optional coverage you may have.

Assignees - You are entitled to convert your share of the insured's FEGLI coverage to an individual direct-pay policy unless, within 3 calendar days after the date the insured's insurance terminated, he/she returns to a Government position that qualifies him/her to reacquire FEGLI coverage. If that is the case, his/her previous assignment is still valid. You may purchase an individual policy in an amount equal to or less than the amount of insurance which the insured assigned to you.

Family members - If, upon termination of the employee's FEGLI coverage, he/she does not convert Option C-Family coverage (if any), you, as an eligible family member, may do so. Spouses may convert up to $5,000, and eligible children up to $2,500 each. Eligible family members are the employee's spouse and unmarried dependent children under age 22 (including adopted children, stepchildren who lived with the employee in a regular parent-child relationship, and recognized natural children) and unmarried dependent children over age 22 who are incapable of self-support because of a mental or physical disability that existed before they reached age 22.

Your time to convert is limited - You must mail your request for information regarding conversion within 31 days of the date in item 3 of Part A above, or within 31 days of the date you receive this notice, whichever gives you more time. If you fail to request conversion information within the 31-day time limit due to a cause beyond your control, you may be allowed to convert your life insurance within six months after the date in item 3, provided you attach a full explanation of what prevented you from making a timely request. If approved, the effective date of the conversion policy will be retroactive to the day following the day group coverage ended.

Note: Under certain circumstances, life insurance is payable if death occurs within 31 days after the group life insurance terminates, regardless of whether conversion has been requested. However, extension of the conversion privilege beyond 31 days does not extend coverage under any circumstances. If death occurs within the 31-day period, further information concerning possible benefits may be obtained from the agency named in item 6 above.

General information about conversion
- If you have assigned your FEGLI coverage, you can **only** convert your Option coverage (if any). Your assignee(s) retain(s) the right to convert your other coverage(s).
- No medical examination is required.
- You or the assignee(s), if applicable, must pay the premium applicable to the individual policy.
- The government will not pay any part of the individual policy premium.
- The individual policy will be issued by an insurance company you select from the list of eligible companies you will receive if you apply for conversion.
- The individual policy may be an ordinary life policy or a variation of ordinary life (see Part D). It must be a type of insurance customarily issued by the insurance company you select. However, it cannot be term insurance or universal life insurance or any other form of life insurance that has an indeterminate premium. It cannot have disability or accidental death and dismemberment benefits.

How to convert
1. Complete the appropriate eligibility statement on the reverse side of this form and mail it to the Office of Federal Employees' Group Life Insurance (OFEGLI), 200 Park Avenue, New York, NY 10166-0188.
2. If you have an SF 2821, Agency Certification of Insurance Status, attach the original (Part 1) to this form when you mail it to OFEGLI. Note: Retiring employees (and assignees of those employees) who are continuing Basic Life insurance but converting one or more of the options should submit their duplicate (Part 2) of the SF 2821with this form to OFEGLI. The original (Part 1) of the SF 2821 should be submitted with the retirement application. OFEGLI will mail you detailed information on how to apply for conversion, together with a list of eligible insurance companies. You have 31 days (from the date in item 3 of Part A above, or the date you receive this notice, wh ichever gives you more time) to request conversion information from OFEGLI.
3. In the event you do not have an SF 2821, you should request a completed form from the employing agency before the expiration of your 31 day time limit and forward it to OFEGLI at the address given in item 1 above. **However, don't delay sending the SF 2819 requesting conversion information to OFEGLI -- send it anyway while you await the SF 2821.**
4. If you are using this form to convert some of your life insurance coverage, but not Option C, have your employing office prepare another SF 2819 for your family members.

FEGLI
Federal Employees Group Life Insurance

Agency Certification of Insurance Status
Federal Employees' Group Insurance Program

To Agency: See reverse for information and instructions

1. Name of employee (Last, first, middle)
2. Date of birth (MM/DD/YYYY)
3. Social Security number

4a. Event requiring certification
- [ ] Separation (includes resignation)
- [ ] Retirement
- [ ] Death as an employee

Had employee filed Application for Retirement (SF 2801 or SF 3107) with OPM?
- [ ] NO
- [ ] YES

- [ ] Death as a reemployed annuitant
- [ ] End of 12 Months non-pay status
- [ ] Other (Specify)

4b. Employees' retirement system
- [ ] CSRS/FERS
- [ ] TVA
- [ ] DCRS*
- [ ] FSRS
- [ ] CIA
- [ ] FICA
- [ ] Other (Specify)

* D.C. Police & Fire/Public School Teachers

4c. OWCP number (if applicable)

5. Disposition of Designations of Beneficiary (SF 54, SF 2823)
- [ ] Attached
- [ ] None on file with this agency
- [ ] On file in employee's Official Personnel Folder

6. Did the employee assign his/her insurance?
- [ ] NO
- [ ] YES (attach RI 76-10)

7. Did the employee elect living benefits?
- [ ] NO
- [ ] YES → Amount elected (Check one and attach EOB)
  - [ ] Partial (post-election BIA $)
  - [ ] Full

8. Date of event checked in item 4a

9. Date of SF 2819, Notice of Conversion Privilege - Issuance Is Mandatory (Prepare SF 2819 for employee whose coverage as an employee terminates, including all retiring employees)

10. Annual basic pay (not basic insurance amount) on date in item 8 (Convert hourly, daily, piecework, etc., rate to annual rate)

11. Effective date of continuous coverage under the FEGLI Program (If any break in service, list dates)

12a. Did employee have Option A - Standard Insurance on date in item 8?
- [ ] NO
- [ ] YES

12b. Amount of Option A

12c. Effective date of election

13a. Did employee have Option C - Family Insurance on date in item 8?
- [ ] NO
- [ ] YES

13b. Effective date of election

14a. Did employee have Option B - Additional Insurance on date in item 8?
- [ ] NO
- [ ] YES

14b. Effective date of election

14c. Number of multiples on date in item 8

14d. Lowest number of multiples during last 5 years

15. Personnel records certification (This form will not be accepted without both personnel and payroll certification.)
I certify that the above information was obtained from, and correctly reflects, official personnel records, and that the employee was covered by Federal Employees' Group Life Insurance on the date in item 8.

15a. Signature of certifying official (Facsimile not acceptable)

15b. Typed name of certifying official

15c. Title

15d. Date

15e. Name and address of agency (Including ZIP Code)

15f. Telephone number (Including area code)

16. Payroll records certification (This form will not be accepted without dual certification.)
I certify that I have compared the annual basic pay shown in item 10, above, with current payroll records and the figures agree.
Payroll deductions were being made or would have been made if the employee had been in pay status for the alpha code (Insurance code and SF 50 equivalent) on the date in item 8. → Alpha code

16a. Signature of certifying official (Facsimile not acceptable)

16b. Typed name of certifying official

16c. Title

16d. Date

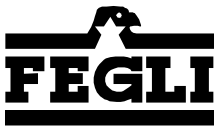
16f. Telephone number (Including area code)

16e. Name and address of payroll office(If different from that given in item 15e)

16g. Payroll office number

Remarks (For agency use only)

OPM use only



Request For Insurance

Federal Employees' Group Life Insurance Program

Carefully read instructions on other side before completing this form.

To: OFFICE OF FEDERAL EMPLOYEES' GROUP LIFE INSURANCE

I hereby apply for cancellation of any waiver or declination of life insurance coverage which I previously filed and request insurance under the Federal Employees' Group Life Insurance Program.

Signature of employee *(must be signed in the presence of an authorized official of your employing agency or authenticated from official records)*	Address *(number, street, city, state, ZIP code)*
Date	

PART A - To Be Completed By Employing Agency

1. Full name of employee *(last, first, middle)*	2. Date of birth *(mo., day, yr.)*	3. Social Security Number
4. Agency in which employed, including bureau or division	5. Location of employment *(city and state)*	

I certify that the signature appearing above is that of the employee named and that the information in Part A, items 1 through 8, has been obtained from and correctly reflects official records.

Name and mailing address of agency *(type or print)*

• **To:**

Signature of certifying agency official	Title
Telephone number	Date

6. Effective date of employee's last life insurance election (SF 2817)

Month *Day* *Year*

7. Will employee be eligible to become insured if this "Request for Insurance" is approved?

☐ Yes ☐ No

8. Has employee had any continuous absence of at least 3 weeks on account of sickness or injury during the past year?

☐ Yes ☐ No

PART B - To Be Completed By Employee

Question	Yes	No	Details
1A. Have you had any change in health in the past 5 years? Do you need medical advice, study or treatment?			1B. If "Yes", briefly note details.
2A. Have you sought medical advice or been treated by a clinic, hospital, physician, or healer within the past 5 years?			2B. If "Yes", briefly note dates, reasons, and treatments.
3A. Have you ever been denied life or health insurance, or offered it at additional rates?			3B. If "Yes", briefly note details.

4A. Have you ever had or were you ever told you had the following:

Condition	Check One: Yes	Check One: No	Condition	Check One: Yes	Check One: No
Chest pain, swollen ankles, or disease of heart or blood vessels?			Unconsciousness, paralysis, epilepsy, or other nervous, muscular, or mental disorder?		
High blood pressure? How high?			Cancer, tumor, polyp, or disease of the blood, spleen, or lymph glands?		
Asthma, emphysema, chronic bronchitis or other lung diseases?			Diabetes, tuberculosis, drug habit, or other defect or disease not mentioned herein?		
Liver conditions, ulcers, or gastrointestinal (G.I.) conditions?			Biopsy, surgical operation, radiation treatment or medical study of a condition not mentioned herein?		
Disease of kidney, bladder, male or female organs, or albumin or sugar in the urine?					

4B. If your answer to any part of question 4(A) is "Yes", briefly state condition, dates, duration, and kind of treatment. Also state names and locations of doctors and hospitals.

The answers I have given in Part B are for the purpose of securing approval of this "Request for Insurance" and I certify that they are true and complete to the best of my knowledge and belief.

Signature of employee *(must be signed in presence of examining physician)*	Date

PART C - To Be Completed By Examining Physician

1. This examination is for Federal Employees' Group Life Insurance purposes. **A prior examination report is not acceptable.**
2. THE EMPLOYEE IS TO PAY YOU THE FEE FOR THIS EXAMINATION. DO NOT PERFORM ANY SPECIAL EXAMINATIONS OR INCUR ANY UNUSUAL EXPENSE.
3. Have the employee sign Part B in your presence.
4. Fully complete, sign and date Part C. Unless specific findings are called for, indicate by checkmark whether findings are normal or abnormal and describe any abnormalities in the space provided.
5. **Do not return the form to the employee, but mail it to:**
   Office of Federal Employees' Group Life Insurance
   4 East 24th Street
   New York, N.Y. 10010

Print employee's full name	M / F	Date of birth *(mo., day, yr.)*

Does examination reveal abnormality of:	Yes	No
General movements, strength, stamina, responsiveness, coordination, etc.?		
Eyes, ears, nose, throat?		
Respiratory system?		
Heart, arteries, or veins? Any murmurs present?		
G.I. system?		
G.U. system?		
Nervous system and reflexes?		
Extremities and skeletal or muscular system?		
Skin and glands?		

Fully describe abnormalities noted or any history of abnormality elicited. *(If more space is needed, please attach additional sheet.)*

I certify that Part B was signed in my presence, that I have carefully examined the individual named above and that my complete findings on examination are correctly recorded.

Height *(centimeters)* or *(feet and inches)*	Weight *(Kilograms)* or *(pounds)*	Signature of examining physician	Date of examination

Blood pressure				Pulse *(at rest)*
Two readings, sitting		Systolic	Diastolic	
diastolic at 5th phase	First reading			
	Second reading			If over 96, pulse after 5 minutes

Name and address of examining physician, including ZIP code

PART D - To Be Completed By OFEGLI

To the employing agency: The employee named on the reverse side may:

☐ Be insured for Basic Life insurance on the first day he or she is in a pay and duty status after the date shown below, or for Option A - Standard and/or Option B - Additional coverage(s) on the first day in a pay and duty status after the date shown below and receipt of "Life Insurance Election" *(SF 2817)* by employing office. If employee is not in a pay and duty status within 31 days after the date shown below, the authorization of insurance is void; the authorization of optional insurance is void unless he or she is in a pay and duty status and has also returned an SF 2817 showing an election of optional insurance within the 31 day grace period.

☐ Not cancel a waiver of insurance coverage or elect optional insurance.

Approving officer	Date of approval

INSTRUCTIONS - *Please read carefully before filling out this form. Failure to observe instructions may result in delay.*

To the employing agency

1. The employee is eligible to request insurance only if he or she is not otherwise excluded from insurance coverage and if one year has elapsed since the effective date of his or her last waiver or declination.
2. Generally, the employee is eligible to request increased Option B-Additional insurance only if one year has elapsed since the effective date of his or her last election affecting the multiples of Option B coverage. However, the employee may request increased Option-B Additional insurance before one year has elapsed if the previous election increased Option B coverage but was limited to the number of family members acquired.
3. Have employee sign the top part on reverse side of this form, then complete Part A and give the form to the employee.
4. Notify the employee of OFEGLI's decision and file the returned form in the employee's OFFICIAL PERSONNEL FOLDER or its equivalent.
5. Have employee execute an SF 2817 only after Part D has been approved by OFEGLI.

To the employee

1. Sign the top part on the reverse side of this form and have your agency complete Part A.
2. Take the form to any medical doctor of your choice. Complete Part B and sign in the presence of the doctor.
3. The doctor should complete Part C and send the form to OFEGLI. The form must be received by OFEGLI within 60 days of the date of the medical examination.
4. The fee for the medical examination must be paid by you directly to the doctor.
5. OFEGLI will notify your agency whether you may be insured and your agency will inform you of the decision.
6. If your request is approved, Basic Life insurance coverage is automatically effective on the first day you are in a pay and duty status after the date of approval; Option A-Standard and/or Option B-Additional, if elected within 31 days of the approval date, are effective the first day you are in a pay and duty status after the approval date and have filed a "Life Insurance Election" (SF 2817), electing optional insurance with your employing office.

Privacy Act Statement - Title 5, U.S. Code, Chapter 87, Life Insurance, authorizes solicitation of this information. The data you furnish will be used by your agency and the Office of Federal Employees' Group Life Insurance to determine your eligibility to receive benefits under the FEGLI Program. This information may be shared with law enforcement agencies when they are investigating a violation or a potential violation of the civil or criminal law. criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number to distinguish you from people with similar names. Furnishing your Social Security Number, as well as the other data, is voluntary, but failure to do so may result in the inability to determine your eligibility for life insurance coverage.

Form Approved
OMB No. 3206-0136

Designation of Beneficiary

Federal Employees' Group Life Insurance Program

Warning
Read instructions on back of duplicate before filling in this form

Information Concerning The Insured: If you have not assigned your insurance, YOU are "the Insured", as used throughout this form.

Name of Insured *(Last, first, middle)*	Date of birth of Insured *(Month, day, year)*	Social Security number of Insured

The Insured is: *Place an "X" in the appropriate box.*	☐ An employee	☐ Retired or an applicant for retirement	☐ Receiving OWCP benefits or an applicant for OWCP benefits	If the Insured is retired or receiving Federal Employees' Compensation, give "CSA", "CSI", or OWCP claim number.

Department or agency in which the Insured is presently employed *(If retired, former department or agency):*

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary or beneficiaries named below to receive any amount of **Life Insurance** and **Accidental Death Insurance** due and payable at the Insured's death.

I understand that if I have previously validly assigned my insurance, any designation completed by me is not valid and has no force and effect.

I understand that this Designation of Beneficiary, if valid, will remain in full force and effect, unless or until canceled by me in writing, or until such time as it is automatically canceled (see back of Part 2). If this designation form is determined invalid for any reason, the next prior valid designation form will be given full force and effect. If no such prior form exists, the proceeds will be distributed under the order of precedence, or, if the insurance has been assigned, to the assignee(s).

Information Concerning The Beneficiary or Beneficiaries (See examples of designations on reverse side):

Type or print first name, middle initial, and last name of each beneficiary	Type or print address *(Including ZIP code)* of each beneficiary	Relationship	Percent or fraction to be paid to each beneficiary

Statement of Insured or Assignee

Print or type **your** name and address *(Including ZIP code)*	Please check: I: ☐ have ☐ have not elected Living Benefits.	Check only one: I am: ☐ the Insured ☐ an Assignee	*Please check:* ☐ I have **not** assigned my insurance. ☐ I have signed this form in the presence of the **two** witnesses who have signed below. ☐ Neither witness is named as a beneficiary. ☐ If I designated shares to be paid to more than one beneficiary, the shares add up to 100%. (*Dollar amounts are not acceptable.)*

For each type of insurance (Basic Life, Option A-Standard, and Option B-Additional): (1) I hereby direct, unless otherwise indicated above, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or become disqualified for any reason from receiving a share of the benefits shall be distributed equally among the surviving beneficiaries, or entirely to the survivor.

(2) I understand that if none of the designated beneficiaries is living at the time of the Insured's death, the proceeds will be distributed under the order of precedence, or, if the insurance has been assigned, to the assignee(s).

I hereby specifically reserve the right to cancel or change this designation of beneficiary at any time without knowledge or consent of the beneficiary(ies).

Signature of Insured/Assignee *(**Only** the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)*	Date of execution *(Month, day, year)*

Witnesses To Signature (A witness is not eligible to receive payment as a beneficiary):

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency	Date of receipt	Signature of authorized agency official	Title

See back of Part 2 for instructions on where to file this form. Do not file with the Office of Federal Employees' Group Life Insurance.

PART 1-Original

U.S. Office of Personnel Management NSN 7540-01-231-6228 Standard Form 2823
The FEGLI Handbook for Personnel and Payroll Offices 2823-102 Previous editions not usable Rev. July 1995

Designation of Beneficiary

Federal Employees' Retirement System

Form Approved
OMB No. 3206-0173

Important
Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(Month, day, year)*	Social Security Number

Place an "X" in the appropriate box.	☐ An employee	☐ Retired or an applicant for retirement	☐ Former employee eligible for retirement in the future	If you are retired give your claim number

Department or agency in which presently employed *(or former department or agency)*:

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees' Retirement System (FERS) after my death. I understand that this designation of beneficiary is also for any lump-sum benefit which may become payable under the Civil Service Retirement System (CSRS) after my death. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my employee deductions for FERS (and CSRS, if applicable).

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of designation *(Mo., day, yr.)*	Your signature		Total = 100%

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date Received	*Signature*	*Date*

Type or print your return address to insure return of copy

See Back of Employee Copy For Instructions On Where To File This Form. (Retain until employee leaves Federal service and then send to OPM)

PART 1-Original

FEDERAL EMPLOYEES RETIREMENT SYSTEM

CERTIFIED SUMMARY OF FEDERAL SERVICE

Office of Personnel Management
5 CFR Part 841

Information for Agency

1. A certified copy of this form must accompany an employee's Application for Immediate Retirement (SF 3107) or an Application for Death Benefits (SF 3104) for a deceased employee if a survivor annuity or a spousal lump sum death benefit appears to be payable.
2. This form may also be used:
   - for retirement counseling purposes
   - to respond to an employee's request for a record of creditable service.

Instructions for Employee

1. Your employing office will complete and certify this form for you
2. Review the form carefully. Be sure it contains all of your service
3. Complete Section E, Employee's Certification, and return it t your employing office.

SECTION A—IDENTIFICATION

1. Name of Employee *(Last, first, middle initial)*

3. Date of Birth *(Month, day, year)*

4. Social Security Number

2. List All Other Names Used *(Maiden name, AKA, spelling variants)*

5. Other Birth Dates Used

6. Military Serial Number

7. Service Computation Date for Retirement Purposes

8. Did this employee elect to transfer to FERS?
☐ No ☐ Yes ► Give effective date of election

9. If yes, is this employee entitled, according to your records, to have part c his/her annuity computed under CSRS rules?
☐ No ☐ Yes

SECTION B—VERIFIED SERVICE HISTORY DOCUMENTED IN OFFICIAL PERSONNEL RECORDS

Federal Agency or Military Service Branch	Appointment, Separation, or Conversion Dates for Civilian and Active Honorable Military Service		Name of Retirement System*	Remarks and Non-Creditable Time**
	From	To		

* Give details of creditable civilian service not subject to retirement deductions in Section C.

** In Remarks, show if CSRS service on an after January 1, 1984, is "regular" CSRS or CSRS offset. Use retirement codes in FPM Supplement 296-33 if necessary to properly identify service.

SECTION C—DETAIL OF CIVILIAN SERVICE NOT SUBJECT TO CONTRIBUTORY RETIREMENT SYSTEM FOR CIVILIAN FEDERAL EMPLOYEES

Detail below (1) any period of Federal civilian service subject only to "FICA" deductions, and (2) any other Federal civilian service not subject to a Federal employee (or D.C. Government) retirement system. If total basic salary earned for any such period of service is known, a summary entry may be entered on the right hand side below. Otherwise, show each change affecting basic salary during the period of service. Service which was not subject to FERS or CSRS deductions is creditable only as specifically allowed by law.

Nature of Action *(Appt., pro., res., etc.)*	Effective Date *(Mo., Day, Year)*	Basic Salary Rate	Salary Basis *(Per annum, per hour, WAE, etc.)*	Leave Without Pay	If Basic Salary Actually Earned Is Available Make Summary Entry Below		
					From *(Mo., Day, Year)*	To *(Mo., Day, Year)*	Total Earned

SECTION D—AGENCY CERTIFICATION

I certify that the information on this form accurately reflects verified information contained in official personnel and/or payroll records in the custody of this agency and that if retiring, the retiring employee has sufficient service for an immediate annuity.

Signature of Authorized Agency Personnel Official		Agency Name and Address, Including ZIP Code, and Telephone Number, Including Area Code
Official Title	Date	

SECTION E—EMPLOYEE'S CERTIFICATION

☐ The service listed is complete.

☐ I have additional service. *(If you claim additional service, attach signed statement giving dates, position, title and location of employment, including agency, bureau and division. Claimed service cannot be credited for retirement until it has been verified, including unverified service listed on a SF 144,* Statement of Prior Federal Civilian and Military Service, *or similar affidavit.)*

Note: If you have performed Federal civilian service subject only to social security deductions (FICA) or not subject to retirement deductions, be sure that your agency has correctly completed Section C above.)

Signature *(Do not print)*	Date

Election of Coverage

Federal Employees Retirement System

Section 1. Instructions for Employee

- Complete this form only if you wish to elect FERS coverage If you wish your currnet coverage to continue, take no action.
- Read information on back of Part 3.
- Make your election in Section 4.
- Complete Section 5.
- Be sure to sign and date in Section 6.
- Return Parts 2 and 3 according to your employing office's instructions.
- Be sure to read your FERS Transfer Handbook.
- If you elect FERS, any CSRS designation of beneficiary (SF 2808) is cancelled. If you want to make a new designation of beneficiary, use SF 3102.

Section 2. Identifying Information (type or print)

Name (Last, first, middle)	Date of Birth (mo,dy,yr)	Social Security Number
77, 78, 79, 821	468	880

Employing Department or Agency	Agency location (City, state, ZIP Code)
16	998, 619, 625

Section 3. Verification of Receipt of Election Form (Employee's signature in this section verifies receipt of this form. It does not constitute an election.)

Employee's signature	Date	Office telephone number
48	506	105

Section 4. Election Place your initials in the box to indicate that you want FERS coverage.

53

I elect FERS coverage. I understand that I will be covered by (1) the Basic Benefits of FERS, (2) the Old Age, Survivors, and Disability Insurance programs of Social Security and (3) the Thrift Savings Plan. I authorize withholdings from my pay for FERS and Social Security purposes. I understand that this decision is irrevocable.

Section 5. Former Spouse Information

Do you have a living former spouse to whom a court order, on file at OPM, awards a portion of your annuity or, if the former spouse has not remarried before age 55, survivor benefits based on your Federal service?

282 Yes → Attach OPM Form 1556, Former Spouse's Consent to FERS Election, your request for waiver of consent requirement, or your request for extension of election deadline in order to modify court order.

281 No

280 I don't know if a court order is on file at OPM. I request OPM to determine whether a qualified court order is on file.

Section 5. Former Spouse Information

I hereby certify that all statements made on this election are true to the best of my knowledge.

Signature	Date
161	219

Warning: Any intentional false statement in this election or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years or both. (18 USC 1001)

For Agency Use Only →

Date of receipt by agency

499

146, 9

FERS

Former Spouse's Consent to FERS Election

Federal Employee's Retirement System

Employee Instructions

Read "Information for Employee" on the back of this form. If a qualifying court order, on file with the Office of Personnel Management, awards a portion of your annuity or a survivor annuity based on your Federal service to a former spouse who has not remarried before reaching age 55, you cannot elect coverage under the Federal Employees Retirement System (FERS) unless your former spouse consents to your election. Complete Part 1 of the form. Have your former spouse complete Part 2. Part 2 must be completed in the presence of a Notary Public or other person authorized to administer oaths. The Notary Public must complete Part 3.

Part 1 – To Be Completed by Employee *(type or print)*

Name *(Last, first, middle)*	Date of birth	Social Security Number
[77, 78, 79, 821]	**[468]**	**[880]**

Part 2 – To Be Completed by Former Spouse of Employee

(Before completing, read "Information For Former Spouse" on the back of this form.)

I freely consent to the election of coverage under the Federal Employees Retirement System made by the employee named in Part 1, who is my former spouse. I understand that my consent is final (not revocable).

Name *(Type or print0*	Signature *(Do not print)*	Date
[181]	**[66]**	**[507]**

Part 3 – To Be Completed by a Notary Public or Other Person Authorized to Administer Oaths

I certify that the person named in Part 2 presented identification (or was known to me), gave consent, signed or marked on the form, and acknowledged that the consent was freely given in my presence on the **[884]** day of **[885]**, 19**[886]** at
(Month) (Year)

[653]
______________________________________.
(City and state)

[186] *(seal)*	Signature **[136]**
	Expiration date of commission if Notary Public **[883]**

Privacy Act Statement

Solicitation of this information is authorized by the Federal Employees Retirement Act (Public Law 99-335). The information you furnish will be used to determine whether the employee's election of coverage may become effective. The information may be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies in order to determine benefits under their programs, to obtain information necessary for determination or continuation of benefits under this program to report income for tax purposes. It may also be shared and verified, as noted above, with law enforcement agencies when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the social security number. Furnishing the Social Security Number as well as other data, is voluntary, but failure to do so may delay or make impossible for us to determine your elgibility to elect FERS coverage.

Employing Office Instructions

When properly completed, this form is considered a part of the employee's election and must be attached to the election form Standard Form 3109, and filed with it as a permanent document on the right side of the employee's OPF.

[146] Standard Form 3110
[9] Date

FERS

Request for Waiver, Extension, or Search
In Connection with Election of FERS Coverage

Before completing this form, read the attached Instructions for Employees and Information for Employees

Section 1. Employee Identifying Information *(type or print)*

Name *(Last, first, middle)*	Date of birth	Social Security Number
[77, 78, 79, 821]	**[468]**	**[880]**

Section 2. Addresses for OPM's Response

Employing office address	Employee's mailing address
[998, 619, 5, 625}	**[74, 75, 1, 73, 17, 135]**

Section 3. Spousal Identifying Information

Former spouse's name *(Last, first, middle)*	Date of birth (Month, day, year)
[181]	**[513]**

Section 3. Request to OPM

A. **[280]** I request that OPM determine whether it has a court order on file that awards benefits to my former spouse identified in Section 3.

B. **[549]** If a court order is on file at OPM, I request that OPM grant me a 6-month extension of time in which I can elect FERS coverage. I understand that the six-month period will run from the date my request is approved.

C. **[550]** If a court order is on file at OPM, I request that OPM waive the requirement that my former spouse consent to my election of FERS coverage based on the attached documentation.

Signature of employee	Date
[48]	**[219]**

Notice to Agency: When OPM returns this form, see "Instructions for Employing Office" on the back of this form.

Section 5. OPM Response *(To Be Completed by OPM)*

[121] OPM does not have on file a qualifying court order awarding CSRS benefits to the employee's former spouse. Proceed with processing the employee's FERS election.

[551] OPM has on file a qualifying court order awarding CSRS benefits to the employee's former spouse. The employee may not elect FERS coverage unless (1) the former spouse consents to the election, or (2) the court order is modified to remove the award of retirement or death benefits to the former spouse

[552] Your request for a six-month extension is approved; it expires on **[887]** . (date)

[553] See attached correspondence regarding your request for a waiver of the former spouse consent requirement.

Signature of OPM official	Date
[58]	**[483]**

Privacy Act Statement

Solicitation of this information is authorized by the Federal Employees Retirement Act (Public Law 99-335). The information you furnish will be used to determine whether the employee's election of coverage may become effective. The information may be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies in order to determine benefits under their programs, to obtain information necessary for determination or continuation of benefits under this program to report income for tax purposes. It may also be shared and verified, as noted above, with law enforcement agencies when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the social security number. Furnishing the Social Security Number as well as other data, is voluntary, but failure to do so may delay or make impossible for us to determine your eligibility to elect FERS coverage.

THRIFT SAVINGS PLAN
ELECTION FORM

TSP-1

Use this form to:
- Start or change your contributions to the Thrift Savings Plan (TSP)
- Stop your contributions to the TSP
- Indicate how you want your future contributions to be invested in the three TSP funds.

Before completing this form, please read the *Summary of the Thrift Savings Plan for Federal Employees* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency employing office.** Do not remove your copy. Your agency will return it to you after completing Section VII.

I. INFORMATION ABOUT YOU

1. ______________________
Name *(Last)* *(First)* *(Middle)*

2. ______________________
Street Address City State Zip Code

3. _______ – _______ – _______
Social Security Number

4. (_______) _______ – _______
Daytime Phone *(Area Code and Number)*

5. ______________________
Date of Birth *(Month/Day/Year)*

6. ______________________
Office Identification *(Agency and Organization)*

II. AMOUNT OF YOUR CONTRIBUTIONS

If you complete this section, you must also complete Section IV.

Complete either Part A or Part B of this section.

Part A. To contribute to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 7) **or** a whole dollar amount per pay period (Item 8).

7. _______ .0% **OR** **8.** $ _______ .00

Part B. If you are a FERS employee who is not, and will not be, contributing to your TSP account at this time, but you are allocating your Agency Automatic (1%) Contributions, check Item 9.

9. ☐ (Noncontributing FERS)

III. STOPPING YOUR CONTRIBUTIONS

Do not complete Section II. FERS employees must also complete Section IV.

To stop your contributions to the TSP, check Item 10 and sign and date Items 15 and 16. If you are a FERS employee, your Agency Automatic (1%) Contributions will continue. You must complete Section IV to show how you want these contributions to be divided among the three TSP funds.

10. ☐ I want to stop contributing to my TSP account. I understand that my payroll deductions will stop at the end of the pay period in which my agency employing office accepts this form.

IV. ALLOCATING CONTRIBUTIONS

You must also complete Section II or III.

Show how you want future contributions to your account to be divided among the G, F, and C Funds. Enter the percentage (in multiples of 5%) that you want invested in each fund. Do not use dollar amounts. The total of Items 11, 12, and 13 must equal 100%. If you are a FERS employee, the percentages that you choose will be applied to all contributions to your account, including Agency Automatic (1%) Contributions and Agency Matching Contributions.

If you invest in either the F or C Fund, you must sign Item 14; otherwise, your form will be returned to you unprocessed.

11. G Fund	Government Securities Investment Fund	.0%
12. F Fund	Fixed Income Index Investment Fund	.0%
13. C Fund	Common Stock Index Investment Fund	.0%
	Total	100.0%

V. ACKNOWLEDGE-MENT OF RISK

Also sign Section VI.

I have chosen to invest in the F and/or C Fund. I understand that I am making this investment at my own risk. I also understand that I am not protected by either the U.S. Government or the Federal Retirement Thrift Investment Board against investment loss in the F or C Fund, and that neither the U.S. Government nor the Federal Retirement Thrift Investment Board guarantees a return on my investment.

14. ______________________
Participant's Signature

VI. SIGNATURE

You must sign Item 15 and date Item 16; otherwise, your form will be returned to you unprocessed.

15. ______________________ **16.** __________
Participant's Signature Date Signed

VII. FOR EMPLOYING OFFICE USE ONLY

17. __________ Payroll Office Number
18. __________ Agency Code
19. __________ Effective Date
20. __________ TSP SCD (Optional)
21. __________ Signature of Employing Office Official
22. __________ Acceptance Date
23. __________ New Eligibility Date if Item 10 Is Checked
24. __________ Remarks