Request For Insurance

Federal Employees' Group Life Insurance (FEGLI) Program

Instructions for Employees

When should I complete this form?
You should complete this form if:

- you are in a position that makes you eligible for FEGLI coverage (ask your human resources office if you don't know), AND
- at least one year has passed since the effective date of your most recent waiver of Basic, Option A and/or Option B life insurance, AND either:

  you are not enrolled in the FEGLI Program, but would like to be, OR

  you are enrolled in the FEGLI Program, but you have less than the maximum life insurance available and you want more life insurance.

What is a waiver of life insurance coverage?
A waiver means you:

- did not elect life insurance coverage when it was available to you, OR
- cancelled coverage you previously had, OR
- elected less than the maximum coverage.

Ask your human resources office if you don't know the effective date of your last waiver, if any.

What coverage can I get by completing this form? You can get Basic, Option A, and Option B, if the Office of Federal Employees' Group Life Insurance (OFEGLI) approves your physical. OFEGLI is an administrative unit of Metropolitan Life Insurance Company that processes these requests and pays claims for the FEGLI Program.

You cannot get Option C by completing this form.

How do I complete this form?

- Ask your human resources office to complete Part A.
- You must complete Part C. Answer all of the questions, or mark N/A (for not applicable). Do not leave an answer blank.
- Bring this form to your physician or other healthcare provider.
- Sign in Part C, in the presence of your physician or other healthcare provider.
- Ask him/her to complete Part D.
- Ask him/her to mail the completed form directly to OFEGLI.
- OFEGLI must receive the form within 60 days of the date of the physical.

Do I have to pay for this physical?
Yes, you must pay any fee for the physical. Your agency or OFEGLI cannot pay for it.

Can I use results of a physical I had last year for another reason?
No. OFEGLI cannot accept a previous physical. Your physician or other healthcare provider must perform the physical for the purposes of this request for life insurance. OFEGLI must receive this form within 60 days of the date of the physical.

What is Basic insurance?
It is life insurance based on your annual salary, rounded up to the nearest thousand dollars (if it is not already an even thousand), plus $2,000. It includes accidental death and dismemberment coverage (payment of more life insurance if you die in an accident or lose a limb or eyesight.)

Basic also includes an Extra Benefit if you are under age 45 when you die. The amount of Basic payable upon your death will be double the regular amount if you are age 35 or under when you die. Starting at age 36, the Extra Benefit reduces by 10 percent per year, until at age 45 there is no Extra Benefit.

What is Option A?
It is life insurance equal to $10,000. It is also called Standard Optional insurance. Option A also includes accidental death and dismemberment coverage.

What is Option B?
It is life insurance equal to 1, 2, 3, 4 or 5 times your annual salary (after rounding your salary up to the nearest thousand dollars, if it is not already an even thousand). It is also called Additional Optional insurance.

What is Option C?
It is life insurance for your family, available in 1 to 5 multiples. Each multiple equals $5,000 for your spouse and $2,500 for each eligible dependent child. It is also called Family Optional insurance. **You cannot elect Option C by completing this form.** You can only elect Option C during an open enrollment period or if you have a life event (marriage, divorce, death of spouse, or adding an eligible child to your family) and you already have Basic.

When is coverage effective?
Basic will be effective on the first day you are in a pay and duty status on or after OFEGLI's approval date.

Option A and/or Option B will be effective on the first day you are in a pay and duty status on or after OFEGLI's approval date and on or after the date your agency receives your SF 2817, *Life Insurance Election.*

However, if you are not in a pay and duty status within 60 days after the approval date you will not have Basic insurance (unless you already had it when you filled out this form), and you cannot elect Option A or Option B. If you do not submit an SF 2817 within those 60 days, you cannot elect Option A or Option B.

What is pay and duty status?
This means you are on duty, receiving pay. You are not on annual leave, sick leave, administrative leave or otherwise absent from duty.

Instructions for Employees *(continued)*

How will I know if OFEGLI approves my physical?
Your human resources office will tell you. OFEGLI contacts your human resources office as soon as it approves or denies your request. You should contact your human resources office if it is more than 2 weeks after the date your physician or other healthcare provider performed the physical and you do not yet know whether OFEGLI approved your physical.

My agency told me that OFEGLI approved my request. What do I do?
If you just want Basic insurance, you do not have to do anything. You will automatically have it on the first day you are in a pay and duty status on or after the date of OFEGLI's approval (as long as you are in a pay and duty status within 60 days of OFEGLI's approval.)

If you want Option A and/or Option B, you must complete SF 2817, *Life Insurance Election*. Your human resources office must receive your form within 60 days after OFEGLI's approval. Sign for Basic and for Option A and/or Option B. Be sure to mark the number of Option B multiples you want to have. Approval of your physical allows you to elect up to a total of 5 multiples of Option B.

Each SF 2817 you complete replaces the previous form. You must sign for all coverage you currently have and wish to keep, AND you must sign for all new coverage you wish to elect. If you have coverage now and do not sign for that coverage, you have cancelled that coverage.

My agency told me that OFEGLI denied my request. Can I appeal?
OFEGLI's decision is final. There are no formal appeal procedures. You or your physician or other healthcare provider may call OFEGLI at 1-800-633-4542 and ask why it denied your request for insurance. Depending on the reason for the denial, you may be able to submit additional medical evidence. OFEGLI may have denied your request because you didn't wait until at least one year after the date of your last waiver of insurance. If so, you can wait until that year has passed, complete another SF 2822, and have another physical. OFEGLI can discuss your options.

Where can I get more information about the FEGLI program?
You can find more information on the FEGLI website at *www.opm.gov/insure/life*. Read the FEGLI Booklet (FE 76-21 or FE 76-20 for Postal employees) and/or the FEGLI Handbook (RI 76-26) (available in electronic format only).

Privacy Act Statement

Chapter 87, title 5, U.S. Code, Federal Employees' Group Life Insurance, authorizes the solicitation of this information. The Office of Federal Employees' Group Life Insurance and your agency will use the data you furnish to determine your eligibility to receive benefits under the FEGLI Program. This 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 or to obtain information necessary for determination or continuation of benefits under this program. It may also be shared and verified with law enforcement agencies when they are investigating a violation or potential violation of civil or criminal law. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security number or tax identification number. This is an amendment to title 31, Section 7701. If you don't furnish the requested information, you may not have the level of insurance protection you want.

Request For Insurance

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Read instructions before completing this form.

Part A Employing Agency

1. Employee's name *(last, first, middle)*	2. Date of birth *mm/dd/yyyy)*	3. Social Security number
4. Employing department/agency *(including bureau or division)*	5. Work location *(city and state)*	6. Employee's daytime phone number ( )
7. Has more than 1 year passed since the effective date of the employee's last waiver or cancellation of FEGLI coverage? ☐ Yes ☐ No	8. Has the employee had any continuous absence of at least 3 weeks because of sickness or injury during the past year? ☐ Yes ☐ No	
9. Signature of certifying agency official		10. Date *(mm/dd/yyyy)*
11. Title of certifying agency official		12. Agency telephone number ( )
13. Name and mailing address of agency *(type or print)* To:		14. Email address, ***if*** you want OFEGLI to email its decision 15. FAX number, ***if*** you want OFEGLI to fax its decision ( )

Part B OFEGLI

1. **To the employing agency:**

☐ We approve this request. ☐ We deny this request.

2. OFEGLI Reviewer	3. Date *(mm/dd/yyyy)*

Instructions for Agencies

When do we complete this form?
Complete Part A of this form whenever an employee asks you to, IF the employee is eligible for life insurance (see below). Be sure to include a complete, legible address where OFEGLI can send you its approval/denial. OFEGLI will not retype this address. It will fold this form and put it in a window envelope if you do not give an email address or fax number. That is why it is vital that your address is clear and complete.

When is an employee eligible?
An employee is eligible if:

- he/she is in a position that allows FEGLI coverage, AND
- at least one year has passed since the effective date of his/her most recent waiver or cancellation of life insurance coverage.

What do we do with the form after completing Part A?
Give the form to the employee. The employee and his/her physician or other healthcare provider must complete the rest of the form and send it to OFEGLI. OFEGLI will consider the results of the physical and either approve or deny the request for insurance.

How will we receive OFEGLI's decision?
OFEGLI will send you its decision in one of three ways: by email, fax or regular mail. If you give an email address in Block 14 above, OFEGLI will email its decision to you. If you don't give an email address, but do give a fax number in Block 15 above, OFEGLI will fax its decision to you. If you only give a mailing address, OFEGLI will mail its decision to you.

When will we receive OFEGLI's decision?
You should receive OFEGLI's decision within 2 weeks after it receives the form from the employee's physician or other healthcare provider. If you have any questions about the status of the decision, please call OFEGLI at 1-800-633-4542. (Note: since this is Personally Identifiable Information (PII), you may need to log in to MetLife's secure email server to access the decision.)

What if OFEGLI approves the request?

- If the employee is not already enrolled in Basic, enroll the employee in Basic, effective on his/her first day in pay and duty status on/after the date of OFEGLI's approval.
- Void the approval if the employee is not in a pay and duty status within 60 days of OFEGLI's approval. The employee does not have Basic unless he/she already had it before completing this form.
- Notify the employee of OFEGLI's approval immediately and tell the employee to submit an SF 2817 within 60 days of OFEGLI's approval, if he/she wants to elect Option A and/or Option B. Coverage is effective on his/her first day in pay and duty status on or after you receive the SF 2817. If the employee is not in a pay and duty status or doesn't submit an SF 2817 within 60 days of OFEGLI's approval, OFEGLI's approval is void. The employee will not have Option A or Option B unless he/she already had that coverage before completing this form.
- File the form in the employee's official personnel folder or its equivalent.

What if OFEGLI denies the request?

- Immediately contact the employee. Tell the employee that he/she doesn't have Basic (unless he/she already had it before completing this form) and cannot elect Option A or Option B. The employee will only have the coverage he/she had before completing this form (if any).
- File the form in the employee's official personnel folder or its equivalent.

Part C Employee

1a. Your address *(number, street, city, state, ZIP code)*

1b. Daytime telephone number ( )

2. Have you had any change in health in the past 5 years?
☐ No ☐ Yes, give details:

3. Have you sought medical advice or been treated by a clinic, hospital, physician, or healer within the past 5 years?
☐ No ☐ Yes, give details:

4. Have you ever been denied life or health insurance, or offered it at higher than normal rates?
☐ No ☐ Yes, give details:

5. Have you ever had or were you ever told you had the following? *Check "Yes" or "No".* If "Yes", explain in 5a.

Chest pain, swollen ankles, or disease of heart or blood vessels?	☐ Yes	☐ No
High blood pressure? How high? _____	☐ Yes	☐ No
Asthma, emphysema, chronic bronchitis or other lung diseases?	☐ Yes	☐ No
Liver conditions, ulcers, or gastrointestinal (G.I.) conditions?	☐ Yes	☐ No
Disease of kidney, bladder, male or female organs, or albumin or sugar in the urine?	☐ Yes	☐ No
Unconsciousness, paralysis, epilepsy, or other nervous or mental disorder?	☐ Yes	☐ No
Cancer, tumor, polyp, or disease of the blood, spleen, or lymph glands?	☐ Yes	☐ No
Diabetes, tuberculosis, or drug habit?	☐ Yes	☐ No
Biopsy, surgical operation, or radiation treatment?	☐ Yes	☐ No
Arthritis or any muscular weakness or disorder?	☐ Yes	☐ No
In the last 5 years, has any physician or health professional diagnosed, treated you for, tested you for, or given you medical advice on injuries or illnesses not shown on this form? If "Yes", give details in 5a. Do not include colds or minor injuries/illnesses that lasted less than 5 days.	☐ Yes	☐ No

5a. Briefly state condition, dates, duration, and kind of treatment. Also state names and locations of doctors and hospitals. *(Use a blank sheet if you need more room.)*

I certify that my answers are true and complete to the best of my knowledge and belief.

6. Your signature *(You must sign in the presence of the examining physician).*

7. Date *(mm/dd/yyyy)*

Part D Examining Physician or Other Healthcare Provider

- This examination is for Federal Employees' Group Life Insurance purposes. ***We cannot accept an earlier exam.***
- ***The employee must pay any fee for this examination. Do not perform any special examinations or incur any unusual expense.***
- Ask the employee to sign Item 6 in Part C in your presence.
- Fully complete, sign and date this part.
- **DO NOT RETURN THIS FORM TO THE EMPLOYEE. MAIL IT TO:**

  Office of Federal Employees' Group Life Insurance
  P.O. Box 6080
  Scranton, PA 18505-6080

1. Print employee's full name *(last, first, middle)*

2. Gender ☐ Male ☐ Female

3. Date of birth *(mm/dd/yyyy)*

4. Height *centimeter* ***or*** *feet and inches*

5. Blood pressure

Two readings, sitting		Systolic	Diastolic
Diastolic at 5th phase	First reading		
	Second reading		

6. Pulse *(at rest)*

6a. If over 96, take pulse after 5 minutes

7. Weight *kilograms* ***or*** *pounds*

8. Does examination reveal abnormality of:

General movements, strength, stamina, responsiveness, coordination, etc.?				☐ Yes	☐ No
Eyes, ears, nose, throat?	☐ Yes	☐ No	Respiratory system?	☐ Yes	☐ No
Nervous systems and reflexes?	☐ Yes	☐ No	Skin and glands?	☐ Yes	☐ No
G.I. system?	☐ Yes	☐ No	G.U. system?	☐ Yes	☐ No
Heart, arteries, or veins?	☐ Yes	☐ No	Any murmurs present?	☐ Yes	☐ No
Extremities and skeletal or muscular system?				☐ Yes	☐ No

9. Fully describe abnormalities. *(Use a blank sheet if you need more room.)*

10. I certify that the employee signed Part C in my presence; that I have carefully examined the employee; and that I correctly recorded my complete findings.
Signature of examining physician or other healthcare provider

Date of examination *(mm/dd/yyyy)*

11. Name and address of examining physician or other healthcare provider

Telephone number ( )