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FEGLI
Federal Employees Group Life Insurance

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:**

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

Signature of certifying agency official	Title
Telephone number	Date

8. Has employee had any continuous absence of at least 3 weeks on account of sickness of injury during the past year?
☐ Yes ☐ No

PART B - To Be Completed By Employee

1A. Have you had any change in health in the past 5 years? Do you need medical advice, study or treatment? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

3B. If "Yes", briefly note details.

4A. Have you ever had or were you ever told you had the following:

	Check One Yes	Check One No		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 opetation, 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.)*

Fully describe abnormalities noted or any history of abnormality elicited. *(If more space is needed, please attach additional sheet.)*

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?		

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 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 Optioon 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 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 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 potential violation of the civil or 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.