United States
**Office of Personnel Management**
Retirement Benefits Branch
1900 E Street NW - Room 2416
Washington DC 20415-0001

Form Approved:
OMB No. 3206-0179

# Disabled Dependent Questionnaire

| 1. Name of disabled dependent *(last, first, middle)* | 2. Dependent's date of birth *(mm/dd/yyyy)* |
|---|---|
| 3. Name of annuitant or deceased annuitant *(last, first, middle)* | 4. Claim number **CS** |

***Complete Part A below and ask the physician to complete Part B on the other side of this form.***

## *Part A - To Be Completed by Disabled Dependent or Dependent's Guardian or Other Fiduciary*

1. Disabled dependent's Social security number →

2a. The unmarried disabled dependent lives:

- ☐ with parent[s] *(go to 2b)* →
- ☐ with guardian or other fiduciary *(go to 2b)* →
- ☐ in a licensed facility *(go to 2b)* →

2b. Please provide the disabled dependent's address and the name of the person that he or she lives with.

2c. ☐ The disabled dependent is married. *(Provide a copy of the marriage certificate, complete item 7, and return the form to us.)*

3. Is there a court appointed guardian or other fiduciary to handle the affairs of the disabled dependent?

- ☐ Yes. If *"yes,"* the guardian or other fiduciary must attach a copy of the court appointment, provide his or her Social Security *(SSN)* or Taxpayer Identification Number *(TIN)*, and complete item 7 below. →

SSN or TIN

- ☐ No

4. Has the disabled dependent been employed during the last twelve months?

☐ Yes ☐ No → *Go to question 6.*

5a. Periods and type of employment:

| From *(mm/dd/yyyy)* | To *(mm/dd/yyyy)* | Description of work performed |
|---|---|---|
| | | |

5b. Total earnings during periods of employment listed in 5a:

**$**

5c. Was employment in a closely supervised environment, eg. closed workshop?

☐ Yes ☐ No

6. Highest level of education of disabled dependent:

**7. Certification**

**I certify that the above statements are true to the best of my knowledge and belief. I hereby authorize the release of medical evidence and information to the Office of Personnel Management (OPM).**

| Signature of disabled dependent, guardian, or other fiduciary | Date *(mm/dd/yyyy)* |
|---|---|
| Telephone number **(  )** | Email address |

*Please have the unmarried disabled dependent's physician complete the back of this form and return the completed form to the above address*

## Part B - To Be Completed by the Physician

*In order to determine if your patient is eligible for benefits under the retirement law, we need information regarding the patient's current medical condition.*

1. Diagnosis of disability:

| 2. Estimate of the expected date of full or partial recovery: | 3. Age at onset: | 4. Severity of disability: ☐ Mild ☐ Moderate ☐ Severe | 5. If patient is mentally disabled, state approximate mental age: | 6. If patient is mentally disabled, give results of IQ tests: |
|---|---|---|---|---|
| | | | | |

***In addition, please attach a narrative (on your letterhead stationery) addressing the following points:***

1. The history of the specific medical condition(s), including references to findings from previous examinations, treatment, and responses to treatment.
2. Clinical findings from your most recent medical evaluation, including findings of physical examinations, results of laboratory tests, X-rays, EKG's and other special evaluations or diagnostic procedures and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests.
3. Assessment of the current clinical status and plans for future treatment.
4. Assessment of the degree to which the medical condition has or has not become static, well stabilized, or controlled, and an explanation of the medical basis for the conclusion.
5. Specify the physical and/or mental limitations or restrictions caused by the patient's medical condition(s).
6. Does the patient's condition preclude or limit self-supporting employment? Explain your answer.
7. If the patient is incapable of self-support, at what age did the patient become incapable?
8. Can the patient handle his or her own finances?

| Signature | Print or type name | Date *(mm/dd/yyyy)* |
|---|---|---|
| | | |

| Address | Telephone number *(including area code)* |
|---|---|
| | E-mail address |

***Return the completed form and the narrative to the address on the front of the form.***

### Privacy Act and Public Burden Statements

Title 5, U.S. Code, Chapters 83, 84, and 89, authorize solicitation of this information. The data you furnish will be used to determine whether the disabled dependent is eligible for continued benefits. 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 to determine benefits under their programs, to obtain information necessary for determination or continuation of benefits under this program, or to report income for tax purposes. It may also be shared 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 the use of the Social Security Number. Provision of this information is voluntary; however, failure to supply all of the requested information may result in our inability to allow benefits.

We estimate providing this information takes an average 60 minutes per response to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for the reducing completion time, to the U.S. Office of Personnel Management (OPM), Retirement Services Publications Team (3206-0179), Washington, DC 20415-0001. The OMB Number 3206-0179 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.