OMB Approval 3206-0162

Report of Medical Examination of Person Electing Survivor Benefits

To the applicant: Complete blocks 1 through 4 then sign your name in block 5.

1. Name *(last, first, middle)*	2. Date of Birth *(mm/dd/yyyy*	3. Social Security Number

4. Do you have any known significant impairment of health or disabling condition which in your opinion could cause death or shorten your normal life expectancy?

☐ No
☐ Yes, If "yes," please explain -

Privacy Act Statement

Pursuant to 5 U.S.C. § 552a(e)(3), this Privacy Act Statement serves to inform you of why OPM is requesting the information on this form. **Authority:** OPM is authorized to collect the information requested on this form pursuant to Title 5, U.S.C, Chapter 83, §8339 (k)(1) which, provides that an employee in good health who is applying for a non-disability annuity, may elect at the time of retirement, a reduced annuity in order to provide a survivor benefit for a person who has an insurable interest. OPM is authorized to collect your Social Security number by Executive Order 9397 (November 22, 1943), as amended by Executive Order 13478 (November 18, 2008). **Purpose:** OPM is requesting this information from both the applicant and the applicant's physician or licensed healthcare professional regarding the applicant's health. This information is used to determine whether the insurable interest survivor benefits election can be allowed. **Routine Uses:** The information requested on this form may be shared as a "routine use" to other Federal agencies and third-parties when it is necessary to process your application. For example, OPM may share your information with other Federal, state, or local agencies and organizations in order to determine benefits under their programs, to obtain information necessary for a determination of your disability retirement benefits, or to report income for tax purposes. OPM may also share your information with law enforcement agencies if it becomes aware of a violation or potential violation of civil or criminal law. A complete list of the routine uses can be found in the OPM/CENTRAL 1 Civil Service Retirement and Insurance Records system of records notice, available at *www.opm.gov/privacy*. **Consequences of Failure to Provide Information:** Providing this information is voluntary. However, failure to provide this information may result in the delay or prevention of granting the survivor reduction to eligible persons. Individuals who do not provide this information can also request changes via telephone or letter, as well as using OPM 1530. The information collected can only be obtained from the respondents.

Public Burden Statement

We estimate this form takes an average of 90 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 reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team (3206-0162), Washington, DC 20415-001. The OMB Number 3206-0162 is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

5. In the presence of the physician or other licensed healthcare professional sign your name in ***ink*** as it appears on your retirement application.	Signature of applicant	Date

To the licensed healthcare professional: You should examine the applicant to determine whether he or she is in good physical condition as can be determined from a routine general medical examination. The Office of Personnel Management will use the information you provide in determining whether the applicant may elect a survivor benefit under the Civil Service Retirement System or the Federal Employees Retirement System. If you need more space for any item(s) attach a separate page. Include on each separate page the identifying information in items 1, 2, and 3 above.

Physical Findings

1. General appearance, including state of nutrition

2. Height		3. Weight	4. Blood Pressure	10. Mouth
Feet	Inches			
5. Skin				11. Neck
6. Gait				12. Heart
7. Eyes				
8. Ears				
9. Nose				13. Lungs

(continued on the reverse side)

14. Abdomen

15. Extremities

16. Reflexes

17. Nervous system

18. History of, or physical findings indicating, a metabolic disorder, blood dyscrasia, or other significant disorder. Indicate laboratory procedure results.

19. Any significant impairment of health or disabling condition not described above should be described here.

20. Conclusion

I certify that the statements made in this report are true to the best of my knowledge.

Signature of licensed healthcare professional	Address *(including Zip Code)*
Name of licensed healthcare professional *(Type or print)*	Date of examination *(mm/dd/yyyy)*