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

OMB Approval 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. →
- ☐ No

SSN or TIN

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 Licensed Healthcare Professional

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 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 by 5 U.S.C. Chapters 83, 84, and 89, which, indicates survivor benefits for unmarried, dependent children, regardless of age, who are incapable of self-support because of mental or physical disability incurred before age 18. 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 in order to determine whether the disabled dependent is eligible for continued benefits. **Routine Uses:** The information requested on this form may be shared externally as a "routine use" to other Federal agencies and third-parties when it is necessary to process your request. 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 suitability, 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 systems 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 may result in our inability to allow benefits.

Public Burden Statement

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.