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

Authority: OPM is authorized to collect this information under 5 U.S.C § 8339(k)(1). OPM collects your Social Security number under Executive Order 9397, as amended by Executive Order 13478. **Purpose**: OPM uses this information to determine whether you meet the medical requirements to elect an insurable interest survivor annuity. **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, if you do not provide the requested information, OPM may be unable to determine whether you qualify to elect an insurable interest survivor annuity.

Public Burden Statement

The public reporting burden to complete this information collection is estimated at 90 minutes per response, including time for reviewing instructions, searching data sources, gathering and maintaining the data needed, and the completing and reviewing the collected information. An agency may not conduct or sponsor, nor is a person required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to the Office of Personnel Management, RS Publications Team at RSPublicationsTeam@OPM.gov. Current information regarding this collection of information – including all background materials -- can be found at https:/www.reginfo.gov/public/do/PRAMain by using the search function to enter either the title of the collection or 3206-0162.

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)*