Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-4500

Name of deceased:_____

❑ Federal annuitant ❑ Spouse of federal annuitant ❑ Survivor annuitant

Name of annuitant: _____

Claim number (CSA or CSF): _____

Social Security number: _____

Date of death: _____

My relationship to the deceased is: ❑ Spouse ❑ Other (specify)

_____

If spouse, my Social Security number is: _____

My date of birth is: _____

I request the following change in enrollment in the Federal Employees Health Benefits Program:
❑ Change for self-and-family to self-only
❑ Continue self-and-family because the deceased is survived by other eligible dependents

Death Certificate: ❑ Enclosed ❑ Will be included with claims

Please provide the undersigned with claim forms for available benefits, if any, at the address below.

Sincerely,

_____

Signature Date

Name: _____

Address: _____

City/State/ZIP: _____

Telephone number: _____ Best time to call: _____