

APPROVED FOR
RELEASE DATE:

Form FE-6 (10-64) 10-Nov-2008

OFFICE OF FEDERAL EMPLOYEES'
GROUP LIFE INSURANCE
4 East 24th Street
New York, New York 10010

CLAIM FOR DEATH BENEFITS
FEDERAL EMPLOYEES' GROUP LIFE
INSURANCE ACT

READ INSTRUCTIONS BEFORE
FILLING OUT THIS FORM.

PART A. GENERAL INFORMATION CONCERNING THE DECEASED

1. FULL NAME OF THE DECEASED (Last) (First) (Middle) MR. MRS. MISS CARANCI, John C.		2. DATE OF BIRTH Month Day Year Feb. 7, 1922		3. DATE OF DEATH Month Day Year Jul. 14, 1970	
4. DEPARTMENT OR AGENCY IN WHICH LAST EMPLOYED, INCLUDING BUREAU OR DIVISION Central Intelligence Agency		5. LOCATION OF LAST EMPLOYMENT (City and State) Washington, D.C.		7. DATE OF FINAL SEPARATION (If Different From Date of Death) Month Day Year Apr. 22, 1970	
6. DOMICILE—(Legal Residence at Time of Death—City and State) CENTERTOWN, Rhode Island		8. WAS DECEASED RETIRED AND RECEIVING ANNUITY UNDER ANY FEDERAL CIVILIAN RETIREMENT SYSTEM, INCLUDING OLD-AGE AND SURVIVORS INSURANCE (SOCIAL SECURITY)? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
9. (a) WAS DECEASED ON ACTIVE DUTY IN THE MILITARY FORCES OF THE U. S. AT TIME OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		9. (b) IF "YES," STATE BELOW			
GIVE CLAIM NUMBER, IF KNOWN.....		BRANCH OF SERVICE	SERIAL NO.	GRADE OR RANK	ORGANIZATION AT TIME OF DEATH (Regiment, Co., etc.)
IF RETIRED, SHOW DATE OF RETIREMENT..... 1/22/70					

IF THE DECEASED NAMED YOU AS BENEFICIARY ON STANDARD FORM 54 attach a receipted copy of the Designation of Beneficiary (Standard Form 54) to this claim, give your age and relationship in the box to the right, and complete Part F. on the other side. IF A RECEIPTED COPY OF STANDARD FORM 54 IS NOT ATTACHED, YOU MUST COMPLETE ALL PARTS OF THIS CLAIM FORM.

Your Age
22
Relationship to Deceased
Son

PART B. PERSONAL INFORMATION CONCERNING THE DECEASED

1. HOW MANY TIMES WAS DECEASED MARRIED? Once	3. GIVE NAME OF EACH SPOUSE (including all former marriages)	4. HOW WAS MARRIAGE TERMINATED? (check one in each case)	5. DATE MARRIAGE WAS TERMINATED
		<input type="checkbox"/> DEATH <input checked="" type="checkbox"/> DIVORCE	Sept. 1964
2. WAS THE DECEASED SURVIVED BY ANY CHILDREN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE	
		<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE	

PART C. INFORMATION CONCERNING THE CLAIMANT

1. YOUR NAME (Last) (First) (Middle) MR. [Redacted]		2. YOUR RELATIONSHIP TO THE DECEASED Son		3. YOUR DATE OF BIRTH Month Day Year	
FILL IN BLANKS 4 THROUGH 14 IF YOU ARE THE WIDOW OR WIDOWER OF THE DECEASED.					
4. DATE OF MARRIAGE Month Day Year		5. PLACE OF MARRIAGE (City and State)		6. MARRIAGE WAS PERFORMED BY <input type="checkbox"/> CLERGYMAN OR JUSTICE OF PEACE <input type="checkbox"/> OTHER (Specify)	
7. WERE YOU LIVING WITH DECEASED AT TIME OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			8. IF NOT LIVING WITH DECEASED AT DEATH, WAS THERE A DIVORCE <input type="checkbox"/> YES <input type="checkbox"/> NO		
9. IF YOU WERE DIVORCED FROM DECEASED, GIVE DATE AND PLACE OF DIVORCE MONTH DAY YEAR CITY STATE			10. IF SEPARATED BUT NOT DIVORCED, ATTACH A SIGNED STATEMENT GIVING COMPLETE DETAILS COVERING PERIOD OF SEPARATION, INCLUDING DATE AND CAUSE OF SEPARATION AND WHY LEFT THE OTHER.		
11. HOW MANY TIMES WERE YOU MARRIED?		12. GIVE NAME OF EACH SPOUSE (Include all former marriages)		13. HOW WAS MARRIAGE TERMINATED? (Check one in each case)	
				<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE	
				<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE	
				<input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE	
				14. DATE MARRIAGE WAS TERMINATED	

FILL IN PARTS D. AND E. ONLY IF YOU ARE NOT THE DESIGNATED BENEFICIARY OR THE WIDOW OR WIDOWER OF THE DECEASED.

PART D. INFORMATION CONCERNING NEXT OF KIN OF DECEASED

List below the name, age, relationship, and address of:

(a) Widow or widower;

(b) If there is no surviving widow or widower, list the child or children of all the deceased's marriages (including adopted child or illegitimate child, stating which class it is) and the descendants of any deceased child or children;

(c) If there are no children, list the parents; if one or both parents are deceased, so state and give the date of death;

(d) If there are no survivors within the degrees indicated in (a) through (c), list the next of kin who may be capable of inheriting from the deceased (brothers, sisters, descendants of deceased brothers, sisters, etc.).

NAME	AGE	RELATIONSHIP TO DECEASED	ADDRESS

FILL IN BLANKS 2. AND 3. ONLY IF ANY OF THE PERSONS LISTED ABOVE ARE UNDER AGE 21.

2. IF A GUARDIAN HAS BEEN APPOINTED BY THE COURT FOR THE ESTATE OF ANY MINOR CHILDREN ABOVE, GIVE NAME AND ADDRESS OF GUARDIAN AND ATTACH COPY OF THE APPOINTMENT PAPER ISSUED BY THE COURT. NATURAL PARENTAGE OR CUSTODY AWARDED AS A RESULT OF A DIVORCE DOES NOT CONSTITUTE GUARDIANSHIP.

NAME

ADDRESS

3. IF A GUARDIAN HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED?

YES

NO

PART E. INFORMATION CONCERNING THE ESTATE OF THE DECEASED

1. IF AN EXECUTOR OR ADMINISTRATOR HAS BEEN APPOINTED BY THE COURT TO SETTLE THE ESTATE OF THE DECEASED, GIVE NAME AND ADDRESS.

NAME

ADDRESS

2. IF AN EXECUTOR OR ADMINISTRATOR HAS NOT BEEN APPOINTED, WILL ONE BE APPOINTED?

YES

NO

PART F. CERTIFICATION BY CLAIMANT

Is claim being made for death benefits by accidental means (injuries solely sustained through violent, external and accidental means)? If "YES" submit coroner's and police reports, news clippings and any other available reports concerning the accident. No claim for such benefits can be considered if the date of insured's separation or retirement is prior to the date injuries were sustained which caused the death of the insured.

YES

NO

I hereby certify that all statements made in this claim are true to the best of my knowledge, information and belief and that no evidence necessary to a settlement of this claim is suppressed or withheld.

(SIGNATURE OF CLAIMANT)

(NAME OF CLAIMANT—TYPE OR PRINT)

(NUMBER AND STREET)

(CITY, STATE, AND ZIP CODE)

WARNING.—Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both, (18 U.S.C. 1001)

August 24 - 1970
(DATE)

AGENCY CERTIFICATION OF INSURANCE STATUS
Federal Employees Group Life Insurance Program

1. NAME (Last) (First) (Middle) Caranci John C.	2(a). DATE OF BIRTH (Month, Day, Year) Feb 7, 1922	2(b). SOCIAL SECURITY ACCOUNT NUMBER
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3. CHECK THE REASON FOR TERMINATING INSURANCE

(a) Separated (includes resignations)
 (b) Retired
 (c) Died as an employee
 (d) Died as a reemployed annuitant
 (e) End of 12 months non-pay status
 (f) Other (specify)

NOTE: If the reason checked is "b, Retired" your group life insurance (but not accidental death and dismemberment benefits) will continue during retirement if you meet the conditions described in "Notice to Retiring Employee" below.

4. CHECK APPROPRIATE BOX CONCERNING SF 54, DESIGNATION OF BENEFICIARY

(a) CURRENT SF 54 ATTACHED (b) A CURRENT SF 54 IS NOT ON FILE WITH THIS AGENCY (c) A CURRENT SF 54 IS ON FILE IN THE EMPLOYEE'S OFFICIAL PERSONNEL FOLDER (OR EQUIVALENT)

NOTE: IF EMPLOYEE (A) DIED OR (B) IS RETIRING OR RECEIVING FEDERAL EMPLOYEES' COMPENSATION UNDER CONDITIONS ENTITLING HIM TO RETAIN HIS LIFE INSURANCE, ATTACH CURRENT SF 54, IF ANY, TO ORIGINAL SF 56 AND CHECK BOX 4 (a) ON ORIGINAL AND ALL COPIES OF SF 56; IF NO CURRENT SF 54 IS ON FILE, CHECK BOX 4 (b). IN ALL OTHER CASES, SHOW WHETHER OR NOT CURRENT SF 54 IS ON FILE BY CHECKING BOX 4 (b) OR (c). A CURRENT SF 54 IS ONE THAT HAS NOT BEEN CANCELED BY EMPLOYEE OR AUTOMATICALLY BY TRANSFER OR PRIOR TERMINATION OF INSURANCE.

5. DATE OF EVENT CHECKED IN ITEM 3 (MONTH, DAY, YEAR) April 22, 1970	6. ANNUAL BASIC PAY RATE (NOT AMOUNT OF INSURANCE) ON DATE IN ITEM 5. CONVERT DAILY, HOURLY, PIECEWORK, ETC. RATE TO ANNUAL RATE. \$14,684 PER ANNUM	7. DID EMPLOYEE HAVE OPTIONAL INSURANCE ON DATE IN ITEM 5? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> IF YES, GIVE RECEIPT DATE OF ELECTION OF OPTIONAL INSURANCE (SF 176 or 176-T):	8. DATE OF NOTICE OF CONVERSION PRIVILEGE (SF 55) TO EMPLOYEE (MONTH, DAY, YEAR)
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9. I CERTIFY THAT THE ABOVE INFORMATION HAS BEEN OBTAINED FROM, AND CORRECTLY REFLECTS, OFFICIAL RECORDS AND THAT THE EMPLOYEE NAMED WAS COVERED BY FEDERAL EMPLOYEES GROUP LIFE INSURANCE ON THE DATE SHOWN IN ITEM 5.

Personal signature of authorized agency official 	Name and address of agency, including zip code
Typed name of authorized agency official 	
Title 	Phone number, including area code
	Date of completion of this form AUG 7 1970

**SEE OTHER SIDE
FOR
INSTRUCTIONS TO EMPLOYING AGENCY**

INSTRUCTIONS TO EMPLOYING AGENCY

COMPLETION OF CERTIFICATION

1. This Certification must be completed in triplicate whenever an employee's insurance terminates for:
 - a. Death.
 - b. Retirement on an immediate annuity with 12 or more years' creditable service, of which at least 5 years are civilian service, or on account of disability. (An immediate annuity is one which begins to accrue not later than 1 month after the date the insurance would normally cease.) In a disability retirement case, do not complete SF 56 until a finding of disability has been officially made and the employee's separation is in order.
 - c. Completion of 12 months in a non-pay status or separation, and the employee is receiving benefits under the Federal Employees' Compensation law, and held unable to return to duty.
 - d. Any other reason, if the employee desires to convert his life insurance, except under the following circumstances:
 - (1) Employee waived or declined on SF 176 (or SF 176-T);
 - (2) If it is known that, within 3 calendar days after the date the insurance terminated, the employee will return to Government service in the same or another position in which he will be eligible to reacquire Federal Employees' Group Life Insurance;
 - (3) More than 75 days have elapsed from the date insurance terminated unless specific request is made therefor by the Civil Service Commission or the Office of Federal Employees' Group Life Insurance.
2. If insurance terminated on account of death, indicate in item 3(a) whether the employee had filed an Application for Retirement (SF 2801) with the Civil Service Commission.
3. In item 8, give date of Notice of Conversion Privilege (SF 55), except that if this form (SF 56) is issued in lieu of SF 55, give current date. In case of death, leave this item blank.
4. It is important whenever a duplicate SF 56 is issued to replace one which has been lost, that it be clearly marked "DUPLICATE".

DISPOSITION OF CERTIFICATION

1. Death of employee—
 - a. Send duplicate of SF 56 immediately to the Office of Federal Employees' Group Life Insurance.
 - b. Keep the original (preferably in the Official Personnel Folder or its equivalent) for attachment to a claim for death benefits (Form FE-6) when received.
 - c. If no claim is received, send original SF 56, upon request, to the Office of Federal Employees' Group Life Insurance.
 - d. If the deceased employee has a current Designation of Beneficiary (SF 54) on file, the SF 54 must be attached to the original SF 56 when it is sent to the Office of Federal Employees' Group Life Insurance.
2. Retirement of employee—
 - a. If the employee is applying for an immediate annuity with 12 or more years' creditable service (of which at least 5 years are civilian service) or for disability, attach the original SF 56 and current Designation of Beneficiary (SF 54), if any, to the Application for Retirement and give duplicate of SF 56 to the employee, [NOTE: In a disability retirement case where the retirement application has already been sent to the Civil Service Commission, attach the original SF 56 (and SF 54, if any) to the "FINAL" Individual Retirement Record (SF 2806).]
 - b. If the employee wants to continue only his regular insurance, have him complete a SF 176 declining his optional insurance. If he wants to convert only his optional insurance, prepare a statement (see below), in duplicate, for him to sign, attach both copies of the statement to the original SF 56, and submit with application for retirement as instructed in 2a above.
Illustrative Statement
"I want to continue my regular insurance after retirement but would like additional information on converting my optional insurance."

_____	_____	_____
(Employee's signature)	(Address—print or type)	(Date)
- c. If the employee prefers to convert both his regular and optional insurance to an individual policy, give him the original and duplicate copy of the SF 56. Retain SF 54, if any.
3. If employee is receiving compensation benefits—
 - a. Before completing item 7 contact the local Bureau of Employees' Compensation Office, if necessary, to confirm whether the employee still has optional insurance.
 - b. Have the employee complete appropriate box on reverse side of the original SF 56. Send original SF 56 and current Designation of Beneficiary (SF 54), if any, to the U. S. CIVIL SERVICE COMMISSION, BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH, WASHINGTON, D. C., 20415, and give duplicate copy of SF 56 to the employee.
 - c. If the employee prefers to convert his group insurance to an individual policy, give him the original and duplicate copy of the SF 56. Retain SF 54, if any.
4. All other cases—
Upon request, give the employee the original and duplicate copy of the SF 56 or mail them to him.
5. In all cases—
Retain file copy of the SF 56 in the employee's Official Personnel Folder or its equivalent.

PROMPT CERTIFICATION REQUIRED

The time in which an employee may convert his group life insurance to an individual policy is limited. This SF 56 must be completed and delivered promptly.