

FEDMER STATEMENT OF PARTICPATION (SOP) --PAGE 2

To be Completed by Agency Representative

This certifies that _____

Employee Name/SSN

has completed the FEDMER package and we are forwarding it to OPM on ____/____/____.
Date

The employee's work status currently is:

(.e.g, LWOP, sick leave, regular work, etc.)

Agency Representative

_____/_____/_____
Date

Agency Representative:

After you complete the first page of this form, please fax **BOTH** pages of this form to the servicing SSA Field Office. Put the original form in the FEDMER package you send to OPM. See <http://www.ssa.gov/phila/fedmr1.htm> for Social Security fax numbers and other information about Social Security Disability claims under FEDMER.

FEDMER BENEFIT VERIFICATION/LEAD

To Servicing SSA Field Office:

From:

Street Address

Name/Agency

City/State/Zip

Phone Number: _____

Fax Number: _____

Fax Number: _____
Additional Comments:

To be completed by the servicing Social Security field office

Social Security Disability Benefit Amount Verification

Based on the "Alleged Onset Date or Date Application Submitted to OPM" (see the last entry in "To Be Completed by Employee" box on the first page of this form), the claimant's estimated SSA Disability benefit amount is: \$_____ per month.

Signature of Field Office Employee/Title

(_____)_____
Phone Number

After completing this section, please fax this page to OPM at (202) 606-4052.

See **RC Memorandum 27-99** for instructions regarding lead/appointment actions to be taken now, subsequent receipt of the FEDMER package, and coding the NOT1 screen on MCS. If you have any questions, please contact the Disability Procedures Team at (215) 597-7490.