

Authorization For Disclosure of Information

Privacy Notice

AUTHORITY: 5 USC 552a

PRINCIPLE PURPOSE: To obtain personal information from family members of deceased Soldiers.

ROUTINE USES: To provide information to third parties and/or members of Congress offering support and condolences in the form of letters, grants, tributes to Soldiers, or other related services as a result of a Soldier death.

DISCLOSURE: Disclosure is voluntary. If the requested information is not provided, the U.S. Army will not provide personal information to third parties and/or members of Congress conducting private relief, tributes to Soldiers, or offering condolences.

Soldier Name: _____

Personal Information To Be Released: (attach continuation sheets as necessary)

<u>Name</u>	<u>Relationship</u>	<u>Age (if minor)</u>
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Address:

Please Initial One of the Options Below:

_____ I hereby authorize the U.S. Army, through its agents including my Casualty Assistance Officer, to release the personal information listed above to **THIRD PARTIES** making an offer of support and condolences in the form of letters, grants, tributes to Soldiers, or other related services. I understand this authorization may be revoked at any time, if requested in writing, except to the extent that action has already been taken. If authorizing the release of personal information concerning a minor, I assert I am the named minor's parent or legal guardian.

_____ I **DO NOT** consent to the disclosure of my personal information to individuals or organizations.

Please Initial One of the Options Below:

_____ I hereby authorize the U.S. Army, through its agents including my Casualty Assistance Officer, to release the personal information listed above to **MEMBERS OF CONGRESS** making an offer of support and condolences in the form of letters, grants, tributes to Soldiers, or other related services. I understand this authorization may be revoked at any time, if requested in writing, except to the extent that action has already been taken. If authorizing the release of personal information concerning a minor, I assert I am the named minor's parent or legal guardian.

_____ I **DO NOT** consent to the disclosure of my personal information to Members of Congress.

Use of Personal Information: The personal information may only be used for the purpose of providing offers of support and condolences in the form of letters, grants, tributes to Soldiers, or other related services as a result of a Soldier death. **ANY DISCLOSURE OF PERSONAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE. THE GOVERNMENT CANNOT GUARANTEE THAT THE ORGANIZATION OR INDIVIDUAL WILL ABIDE BY THE AGREEMENT TO NOT FURTHER DISCLOSE THE INFORMATION.**

Signature of Person/Parent/Guardian

Date

Signature of Person/Parent/Guardian

Date

CRITICAL DOCUMENT – SEVEN QUESTIONS FOR NEXT OF KIN (NOK) & CASUALTY ASSISTANCE OFFICER (CAO)

ATTN CAO: Complete this document **ONLY IN THE PHYSICAL PRESENCE OF THE SOLDIER'S NEXT OF KIN (NOK)**, and return it to CMAOC **within three (3) days**. Answers must be complete, detailed, and precise, as they will be submitted for preparation of official Letters of Condolence. Pentagon personnel may call you to verify data you provide on this form at any time.

★**NOK's Relationship to Soldier** (e.g. father, mother, spouse, child, stepparent, stepchild, etc.): _____

① **Soldier's Name** (use proper spelling and punctuation, e.g. "José Sánchez Nuñez" - note letters "e," "a," and "n" are replaced with the accented characters "é," "á," and "ñ." If no middle name, state "NONE"):

FIRST	MIDDLE	LAST (note any hyphen)	SUFFIX (Sr., Jr., III)
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② **By what name does the NOK want the Soldier referred to on official correspondence?** (restrictions may apply)

③ **Soldier's Complete Unit of Assignment** (spell out full unit designation; **DO NOT** use acronyms):

CO/TRP/DET	BN/SQDN	BDE/RGT	DIV/CMD	INSTALLATION/STATE
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④ **Next of Kin's Professional Title**, if any (e.g. "Doctor," "Reverend," etc.) If Military, note branch of service, Rank, Active or Retired status, and number of years served):

⑤ **Next of Kin's Name** (include Mr./Mrs./Ms. Use proper spelling and punctuation, e.g. "Mr. José Sánchez Nuñez" – note letters "e," "a," and "n" are replaced with accented letters "é," "á," and "ñ." If no middle name, state NONE.)

TITLE (Mr./Mrs./Ms.)	FIRST	MIDDLE	LAST (note any hyphen)	SUFFIX (Sr., Jr., III)
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By what name does the NOK want to be addressed on official correspondence? (restrictions may apply)

⑥ **Next of Kin's Address** for the next **60** days (U.S. Postal Service-verified physical address; add mailing address or P.O. Box if different from physical address). Address must also be able to receive UPS deliveries:

STREET	CITY	STATE	ZIP CODE + 4
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⑦ **CAO's Complete Information** (if no middle name, state "NONE"):

RANK	FIRST	MIDDLE	LAST	COMPONENT (AC, USAR, OR ARNG)
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CO/TRP/DET	BN/SQDN	BDE/RGT	DIV/CMD	INSTALLATION/STATE
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CAO's 60-Day Mailing Address*: _____

*If the NOK mailing address is a P.O. Box, certain correspondence may be sent to the CAO for hand delivery to the NOK.

CAO - Sign and Date Below: _____

CAO's Signature	DATE
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PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Section 301; Departmental Regulations; 37 U.S.C. Section 404, Travel and Transportation Allowances, General; DoD Directive 5154.29, DoD Pay and Allowance Policy and Procedures; Department of Defense Financial Management Regulation (DoDFMR) 7000.14.R., Volume 9; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To provide an automated means for computing reimbursements for individuals for expenses incurred incident to travel for official Government business purposes and to account for such payments.

Applicable SORN: T7333 (<http://privacy.defense.gov/notices/dfas/T7333.shtml>).

ROUTINE USE(S): Certain "Blanket Routine Uses" for all DoD maintained systems of records have been established that are applicable to every record system maintained within the Department of Defense, unless specifically stated otherwise within the particular record system notice. These additional routine uses of the records are published only once in each DoD Component's Preamble in the interest of simplicity, economy, and to avoid redundancy. Applicable SORN: <http://dpclo.defense.gov/privacy/SORNs/component/dfas/preamble.html>.

DISCLOSURE: Voluntary; however, failure to furnish the requested information may result in total or partial denial of the amount claimed. The Social Security Number is requested to facilitate the possible collection of indebtedness or credit to the DoD traveler's pay account for any residual or shortage.

PENALTY STATEMENT

There are severe criminal and civil penalties for knowingly submitting a false, fictitious, or fraudulent claim (U.S. Code, Title 18, Sections 287 and 1001 and Title 31, Section 3729).

INSTRUCTIONS

ITEM 1 - PAYMENT

Member must be on electronic funds (EFT) to participate in split disbursement. Split disbursement is a payment method by which you may elect to pay your official travel card bill and forward the remaining settlement dollars to your predesignated account. For example, \$250.00 in the "Amount to Government Travel Charge Card" block means that \$250.00 of your travel settlement will be electronically sent to the charge card company. Any dollars remaining on this settlement will automatically be sent to your predesignated account. Should you elect to send more dollars than you are entitled, "all" of the settlement will be forwarded to the charge card company. Notification: you will receive your regular monthly billing statement from the Government Travel Charge Card contractor; it will state: paid by Government, \$250.00, 0 due. If you forwarded less dollars than you owe, the statement will read as: paid by Government, \$250.00, \$15.00 now due. Payment by check is made to travelers only when EFT payment is not directed.

REQUIRED ATTACHMENTS

1. Original and/or copies of all travel orders/authorizations and amendments, as applicable.
2. Two copies of dependent travel authorization if issued.
3. Copies of secretarial approval of travel if claim concerns parents who either did not reside in your household before their travel and/or will not reside in your household after travel.
4. Copy of GTR, MTA or ticket used.
5. Hotel/motel receipts and any item of expense claimed in an amount of \$75.00 or more.
6. Other attachments will be as directed.

ITEM 15 - ITINERARY - SYMBOLS

15c. MEANS/MODE OF TRAVEL (Use two letters)

GTR/TKT or CBA (<i>See Note</i>)	- T	Automobile	- A
Government Transportation	- G	Motorcycle	- M
Commercial Transportation		Bus	- B
(<i>Own expense</i>)	- C	Plane	- P
Privately Owned		Rail	- R
Conveyance (POC)	- P	Vessel	- V

Note: Transportation tickets purchased with a CBA must not be claimed in Item 18 as a reimbursable expense.

15d. REASON FOR STOP

Authorized Delay	- AD	Leave En Route	- LV
Authorized Return	- AR	Mission Complete	- MC
Awaiting Transportation	- AT	Temporary Duty	- TD
Hospital Admittance	- HA	Voluntary Return	- VR
Hospital Discharge	- HD		

ITEM 15e. LODGING COST

Enter the total cost for lodging.

ITEM 19 - DEDUCTIBLE MEALS

Meals consumed by a member/employee when furnished with or without charge incident to an official assignment by sources other than a government mess (*see JFTR, par. U4125-A3g and JTR, par. C4554-B for definition of deductible meals*). Meals furnished on commercial aircraft or by private individuals are not considered deductible meals.

29. REMARKS

- a. INDICATE DATES ON WHICH LEAVE WAS TAKEN:
- b. ALL UNUSED TICKETS (*including identification of unused "e-tickets"*) MUST BE TURNED IN TO THE T/O OR CTO.

DISPOSITION OF REMAINS STATEMENT

For use of this form, see AR 638-2; the proponent agency is DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10 USC, Sections 1481 through 1488; EO 9397.
PRINCIPAL PURPOSE: To record disposition of remains desired by the person authorized to direct disposition of remains (PADD).
ROUTINE USES: By Department of Army to enable PADD to apply for authorized benefits.
DISCLOSURE: Disclosure of requested information is voluntary; however, if not provided, benefits cannot be provided.

1. NAME OF DECEASED (<i>Last, First, Middle Initial</i>)	2. RANK OF DECEASED	3. SSN OR SERVICE NUMBER OF DECEASED
4. NAME AND ADDRESS OF PADD		5. RELATIONSHIP TO DECEASED

6. DESIRED DISPOSITION OF REMAINS (*Check and initial appropriate option*)

OPTION 1 <input type="checkbox"/> _____ (<i>Initials</i>)	The remains be prepared, dressed, casketed and transported to the funeral home named below with subsequent interment in a civilian cemetery. NAME AND ADDRESS OF FUNERAL HOME AND, IF KNOWN, CIVILIAN CEMETERY: MY CHOICE OF CASKET IS: (<i>Select one</i>) <input type="checkbox"/> METAL <input type="checkbox"/> WOOD Reimbursement for interment expenses not to exceed \$ _____
OPTION 2 <input type="checkbox"/> _____ (<i>Initials</i>)	The remains be prepared, dressed, casketed and transported to the funeral home named below with subsequent interment in a Government cemetery. NAME AND ADDRESS OF FUNERAL HOME AND GOVERNMENT CEMETERY: MY CHOICE OF CASKET IS: (<i>Select one</i>) <input type="checkbox"/> METAL <input type="checkbox"/> WOOD Reimbursement for interment expenses not to exceed \$ _____
OPTION 3 <input type="checkbox"/> _____ (<i>Initials</i>)	The remains be prepared, dressed, casketed and transported direct to Government cemetery named below. NAME AND ADDRESS OF GOVERNMENT CEMETERY: MY CHOICE OF CASKET IS: (<i>Select one</i>) <input type="checkbox"/> METAL <input type="checkbox"/> WOOD Reimbursement for interment expenses not to exceed \$ _____
OPTION 4 <input type="checkbox"/> _____ (<i>Initials</i>)	The remains be prepared, dressed, casketed, and transported to the funeral home named below with subsequent cremation at Government expense, arranged by the person with legal authority at the final destination. NAME AND ADDRESS OF FUNERAL HOME AND CEMETERY: <input type="checkbox"/> I INTEND TO RETAIN POSSESSION OF THE CREMATED REMAINS. MY CHOICE OF CASKET IS: (<i>Select one</i>) <input type="checkbox"/> METAL <input type="checkbox"/> WOOD MY CHOICE OF URN IS: (<i>Select one</i>) <input type="checkbox"/> BRONZE <input type="checkbox"/> WOOD Reimbursement for interment expenses not to exceed amounts in options 1 and 2 depending on interment in a civilian or Government cemetery. The reimbursable amount when the cremated remains are retained and not interred is the same as for option 2.
OPTION 5 <input type="checkbox"/> _____ (<i>Initials</i>)	I desire to make all arrangements. Release remains to the following funeral home. NAME AND ADDRESS OF FUNERAL HOME: Reimbursement for casket, preparation of remains, and interment in a private cemetery \$ _____ Reimbursement for casket, preparation of remains, and interment in a government cemetery \$ _____ Reimbursement of transportation charges for transportation of remains not to exceed amount it would have cost the Government to transport the remains. The reimbursable amount when the cremated remains are retained and not interred is the same as for Government cemetery.
OPTION 6 <input type="checkbox"/> _____ (<i>Initials</i>)	I, the undersigned, having the paramount right and responsibility to direct the disposition of the remains, HEREBY RELINQUISH MY RIGHTS to direct the disposition of the remains. I understand that the right to direct disposition of the remains will pass to the next person in order of precedence. I also certify that I have the legal right to make this authorization and release the U.S. Army, its officers, agents and employees from any and all liability which may arise from this relinquishment.

7. AUTHORIZATION: I, the undersigned, authorize the release of remains and desire disposition to be effected as indicated above.		a. DATE (YYYYMMDD)
b. TYPED OR PRINTED NAME OF WITNESS	d. TYPED OR PRINTED NAME OF PADD	
c. SIGNATURE OF WITNESS	e. SIGNATURE OF PADD	

DISPOSITION OF REMAINS ELECTION STATEMENT INITIAL NOTIFICATION OF IDENTIFIED PARTIAL REMAINS

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 10 USC, Sections 1481 through 1488,
Principal Purpose: To record disposition of remains desired by the person authorized to direct disposition of remains (PADD).
Routine Uses: By Departments of the Army, Navy and Air Force to document and authorize actions necessary to return the remains.
Disclosure: Disclosure of requested information is voluntary. Without disclosure your desires may not be recorded and accommodated.

1. NAME OF DECEASED (Last, First, Middle Initial)	2. SERVICE / RANK OF DECEASED	3. SSN OF DECEASED
4. TYPED OR PRINTED NAME OF PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD)		5. RELATIONSHIP TO DECEASED

I, the undersigned, understand that every effort is being made for the full recovery of remains, but only partial remains have been recovered and identified at this time. I am aware that additional subsequent remains may be recovered at a later date and individually identified or designated for inclusion with a group. I elect the following options from the applicable sections below. **NOTE: Always complete sections I & II; additionally complete section III for a multiple casualty incident.**

Section I: Election for Currently Recovered Remains

Option 1 _____ Initials	I would like to receive the incomplete remains that have been identified at this time.
Option 2 _____ Initials	I would like to have the incomplete remains temporarily held until other substantial remains believed to be from the deceased are identified. I understand that this process can take up to a week or more.

Section II: Election In the Event of Future Individual Identification

Option 1 _____ Initials	In the event that further remains are individually identified, I would like to be notified and given the choice of accepting subsequent portions for disposition.
Option 2 _____ Initials	In the event that further remains are individually identified, I DO NOT want to be notified. I authorize the Army, Marine Corps, Navy, Air Force or Coast Guard to make appropriate disposition.

Section III: Election In the Event of Future Group Designation (Multiple Casualty Incident)

Option 1 _____ Initials	In the event that further remains are designated for inclusion with a group, I would like to be notified and provided information on any planned ceremony in honor of deceased Service members in the group.
Option 2 _____ Initials	In the event that further remains are designated for inclusion with a group, I DO NOT want to be notified.

Authorization of PADD and Witness

SIGNATURE OF PADD	DATE
TYPED OR PRINTED NAME OF WITNESS (Last, First, MI, Rank/Grade, Title)	
SIGNATURE OF WITNESS	DATE

**DISPOSITION OF REMAINS ELECTION STATEMENT
NOTIFICATION OF SUBSEQUENTLY IDENTIFIED PARTIAL REMAINS**

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 10 USC, Sections 1481 through 1488

Principal Purpose: To record disposition of remains as directed by the Person Authorized to Direct Disposition of the remains (PADD).

Routine Uses: By Departments of the Army, Navy, and Air Force to document and authorize actions necessary to return the remains.

Disclosure: Disclosure of requested information is voluntary. Without disclosure your desires may not be recorded or accommodated.

NAME OF DECEASED (<i>Last, First, Middle Initial</i>)	SERVICE / RANK OF DECEASED	SSN OF DECEASED
TYPED OR PRINTED NAME OF PADD		RELATIONSHIP TO DECEASED

I, the undersigned, understand that partial additional remains have been recovered and individually identified for the decedent listed above.

I hereby direct and authorize that the additional remains be: (*select one option below*)

Option 1 _____ <i>Initial</i>	Transferred for interment in a suitable burial container above the original casket to: <i>Funeral Home</i> _____ <i>Name and</i> _____ <i>Address</i> _____
Option 2 _____ <i>Initial</i>	Transferred to the funeral home below for subsequent cremation at Government expense, arranged by the person with legal authority at the final destination: Urn Choice: Metal _____ Wood _____ <i>Funeral Home</i> _____ <i>Name and</i> _____ <i>Address</i> _____
Option 3 _____ <i>Initial</i>	Cremated, placed in a Metal _____ or Wood _____ urn and delivered to: <i>Name and</i> _____ <i>Address</i> _____
Option 4 _____ <i>Initial</i>	Retained at the Servicing Mortuary for appropriate disposition by the parent Service.
Option 5 _____ <i>Initial</i>	Retained by the Armed Forces Medical Examiner System for teaching and research purposes with final disposition as a medical specimen.

In the event that further subsequent remains are identified beyond today (select Notify or Do Not Notify):

NOTIFY	You may select one or both _____ I would like to be notified and given the choice of accepting individual portions for disposition. _____ I would like to be notified in the event that further remains are classified as part of a group , so that I can be provided information on any planned ceremony in honor of Service members in the group.
DO NOT NOTIFY	_____ I DO NOT want to be notified. I authorize the parent Service to make appropriate disposition.

AUTHORIZATION OF PADD AND WITNESS

SIGNATURE OF PADD		DATE
TYPED OR PRINTED NAME OF WITNESS	SIGNATURE OF WITNESS	DATE

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ELECTION FOR AIR TRANSPORTATION OF REMAINS FROM A THEATER OF COMBAT OPERATIONS

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 10 USC, Sections 1481 through 1488

Principal Purpose: To record air transportation of remains desired by the person authorized to direct disposition of remains (PADD).

Routine Uses: By Departments of the Army, Navy and Air Force to document and authorize actions necessary to return the remains.

Disclosure: Disclosure of requested information is voluntary. Without disclosure your desires may not be recorded and accommodated.

NAME OF DECEASED (Last, First, Middle Initial)	SERVICE / RANK OF DECEASED	SSN OF DECEASED
TYPED OR PRINTED NAME OF PADD		RELATIONSHIP TO DECEASED
COMPLETE ADDRESS OF PADD		PHONE NUMBER(S)

As the Person Authorized to Direct Disposition (PADD) of remains, I acknowledge the air transportation options available to me, and my choice is reflected below.

Option 1 _____ Initials	I direct that the remains be transported by military / military contracted aircraft to an airport or military base appropriate to the receiving funeral home or interment site.
Option 2 _____ Initials	I direct that the remains be transported by commercial aircraft to an airport appropriate to the receiving funeral home or interment site.
<u>NOTES:</u>	

GENERAL WAIVER _____ Initials	In the unlikely event that the choice of air transportation selected above is delayed due to circumstances beyond the military Services' control, I authorize the military Service to arrange other transportation, if required, to ensure the timely arrival of my loved one's remains.
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Authorization of PADD and Witness

SIGNATURE OF PADD	DATE
TYPED OR PRINTED NAME OF WITNESS	
SIGNATURE OF WITNESS	DATE

CJMAB Form 4 GUIDE

Points listed below are provided to aid Casualty Assistance Officers or Mortuary Affairs Officers in explaining to the person authorized to direct disposition (PADD) the air transport options for remains of Service members who die in a combat theater of operations.

- All remains of Service members who die in a combat theater of operations are brought to the mortuary facility at Dover Air Force Base, Delaware, for identification and final preparation.
- The person authorized to direct disposition (PADD) provides written instructions to the Military Service indicating where he/she wants the remains returned.
- If the transportation of remains requires transportation by air, legislation requires that the Armed Services provide military aircraft or military contracted aircraft, unless otherwise directed by the PADD, to the destination selected by the PADD.
- The aircraft will depart from Dover Air Force Base, Delaware and arrive at the nearest useable military or civilian airport servicing the location selected by the PADD for funeral services.
- Military air or military contracted air is not as robust as scheduled aircraft through the commercial airline industry, but may fly to non-commercial airports that are more direct and closer to the final destination. Commercial flights are generally more available but are limited to commercial airports which may not be closest to the final destination.
- CJMAB Form 4 has been developed to document the PADD's air transport decision. The form has two options and a General Waiver.
 - Option 1 directs military airlift support to the airport nearest to the funeral home, or interment site selected by the PADD, as can be accomplished by the Services.
 - Option 2 allows for the transportation of remains by Commercial airlines however, flights are limited to commercial airports which may not be the closest location to the receiving funeral home.
 - A notes section is provided to record any known comments or wishes of the PADD; especially if there is a specific military or commercial airfield that the PADD would prefer as a first option.
 - General waiver allows the appropriate Service to select the method of transportation which will return the Service member in the most expeditious manner.
- The PADD will be kept fully informed of the transportation schedule to include date, time and location of arrival of remains.

DISPOSITION OF ORGANS RETAINED FOR EXTENDED EXAMINATION

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. NAME OF DECEASED	2. RANK OF DECEASED	3. LAST FOUR OF SSN
4. TYPED/PRINTED NAME OF PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD)		5. RELATIONSHIP

6.

I, the undersigned, understand that the _____ has/have been retained
(Specify organs retained)

by the Armed Forces Medical Examiner System for the purpose of extended examination to determine the cause and manner of death. This extended examination may take up to six months.

Armed Forces Medical Examiner System understands that the retention of organs can be a troubling and confusing issue. Please contact us at (301) 319-0000 at any time, day or night, if you have any questions regarding this extended examination or this form. After the examination is complete, you will receive a follow-up letter from the Armed Forces Medical Examiner System confirming your selection of disposition of the retained organ(s).

Upon completion of the extended examination, I elect the following option by placing my initials next to the option of my choice:

_____ **Do not notify me.** I authorize the Armed Forces Medical Examiner System to make proper disposition.
Initials

_____ **Notify me** when examination is complete and give me the opportunity to decide the disposition of the above-mentioned retained organ(s).
Initials

CONTACT TELEPHONE: 301-319-0000 - ARMED FORCES MEDICAL EXAMINER Main Office
24 hours a day, 7 days a week

AUTHORIZATION OF PADD AND WITNESS SIGNATURE

7. TYPED OR PRINTED NAME OF PADD	8. SIGNATURE OF PADD	9. DATE
10. TYPED OR PRINTED NAME OF WITNESS	11. SIGNATURE OF WITNESS	12. DATE

ELECTION FOR TRANSPORTATION OF REMAINS WHEN DISTANCE IS LESS THAN 300 MILES

DATA REQUIRED BY THE PRIVACY ACT OF 1974		
Authority: Army Regulation 638-2, Chapter 11, revised July 2007 Principal Purpose: To record mode of transportation of remains desired by the person authorized to direct disposition of remains (PADD) Routine Uses: By Department of the Army to document and authorize actions necessary to return the remains. Disclosure: Disclosure of requested information is voluntary. Without disclosure, your desires may not be recorded and accommodated.		
NAME OF DECEASED (Last, First, Middle Initial)	RANK OF DECEASED	SSN OF DECEASED
TYPED OR PRINTED NAME OF PADD		RELATIONSHIP TO DECEASED
COMPLETE ADDRESS OF PADD		TELEPHONE NUMBER(S)

As the Person Authorized to Direct Disposition (PADD) of remains, I acknowledge the transportation policy below and understand my option to select the mode of transportation for the mid-range distance. My choice is reflected below. Distances described are from the preparing mortuary/ funeral home to the receiving funeral home designated on the DA Form 7302.

- **Less than 150 miles**, transportation will be via HEARSE contracted by the Army.
- **Between 150-300 miles**, the PADD may elect the mode of transportation – either hearse or air transportation. My election is:
 - _____ HEARSE
 - _____ AIR (For Theater/Theater-related deaths, a CJMAB Form 4 is also required.)
- **Greater than 300 miles**, transportation will be via AIR. (For Theater/Theater-related deaths, a CJMAB Form 4 is also required.)

GENERAL WAIVER	In the unlikely event that my choice of transportation indicated above is delayed due to circumstances beyond the Army's control, I authorize the Army to arrange other transportation, if required, to ensure the timely arrival of my loved one's remains.
_____ Initials	

Authorization of PADD and Witness:

SIGNATURE OF PADD	DATE
TYPED OR PRINTED NAME OF WITNESS	
SIGNATURE OF WITNESS	DATE

REQUEST FOR PAYMENT OF FUNERAL AND/OR INTERMENT EXPENSES

OMB No. 0704-0030
OMB approval expires
May 31, 2006

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0030). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE ADDRESS IN ITEM 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488; EO 9397.
PRINCIPAL PURPOSE: To record amount of funeral and/or interment expenses incurred by next of kin.
ROUTINE USES: None.
DISCLOSURE: Disclosure of requested information is voluntary; however, if not furnished, claim cannot be paid.

PART I - TO BE COMPLETED BY MILITARY AUTHORITIES

1. MILITARY ACTIVITY PREPARING THIS FORM		2. MILITARY ACTIVITY FORM IS TO BE MAILED TO FOR PAYMENT	
a. NAME		a. NAME	
b. ADDRESS (Street, City, State and ZIP Code)		b. ADDRESS (Street, City, State and ZIP Code)	
3. NAME OF DECEDENT (Last, First, Middle Initial)	4. PAY GRADE/RANK	5. SERVICE NUMBER/SSN	
6. PLACE OF DEATH (City, State, Country)		7. DATE OF DEATH (YYYYMMDD)	
8. NAME OF CLAIMANT (Last, First, Middle Initial)		9. RELATIONSHIP	
10. FUNERAL HOME AND/OR NATIONAL CEMETERY			
a. NAME		b. ADDRESS (Street, City, State and ZIP Code)	

11. GOVERNMENT CONTRACT FOR CARE OF REMAINS IN EFFECT AT PLACE OF DEATH

NO **YES** (Enter name of contracting activity)

PART II - TO BE COMPLETED BY CLAIMANT (Proper completion will expedite settlement.)

- a. Complete Items 12 and 13.
- b. Complete either Item 14, 15, or 16. (Do not complete more than one.)
- c. Complete Item 17, when cost of shipment of remains is claimed in Item 15 or as Item 16.
- d. Attach copies of bills for all amounts claimed.
- e. Mail completed form to addressee shown in Item 2.

12. CEMETERY, MAUSOLEUM OR OTHER DISPOSITION		13. DATE OF INTERMENT (YYYYMMDD)
a. NAME	b. ADDRESS (Street, City, State and ZIP Code)	

14. INTERMENT COSTS (To be completed when claimant arranged for interment only.) Enter total amount paid or incurred for one or more of the following: Cost of single grave site, opening and closing grave, burial vault, church service or clergy's fee, obituary notice, flowers, services of funeral director, including use of funeral director's facilities, and motor service.	AMOUNT CLAIMED \$
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15. FUNERAL ARRANGEMENT COSTS (To be completed when claimant made all arrangements.) Enter total amount paid or incurred for one or more of the following: Casket, preservation (embalming) and related services, cremation and urn, clothing for deceased, cost for interment (single grave site, opening and closing grave, burial vault, church service or clergy's fee, obituary notice, flowers, services of funeral director, including use of funeral director's facilities, and motor service), and shipment of remains (removal from place of death to preparation point, delivery from preparation point to common carrier, shipping costs, removal from common carrier to receiving funeral home, and delivery to cemetery).	AMOUNT CLAIMED \$
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16. SHIPPING COSTS OF REMAINS (To be completed when claimant paid or incurred cost for shipment of remains.) Enter total amount paid or incurred for one or more of the following: Removal from place of death to preparation point, delivery from preparation point to common carrier, shipping costs, removal from common carrier to receiving funeral home, and delivery to cemetery.	AMOUNT CLAIMED \$
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17. SHIPMENT OF REMAINS (Complete when shipping costs claimed.)

a. SHIPPED FROM (City and State)	b. SHIPPED TO (City and State)	c. MODE OF SHIPMENT (X one)
		<input type="checkbox"/> AIR <input type="checkbox"/> HEARSE

18. STATEMENT OF CLAIMANT: I have paid or incurred expenses in the amounts entered in Items 14, 15, and/or 16. I desire that the amount allowable by the Government be paid to:

a. NAME OF PAYEE (Print or type)	b. TAXPAYER ID NUMBER OR SSN
c. ADDRESS OF PAYEE (Street, City, State and ZIP Code)	d. SIGNATURE OF CLAIMANT
	e. DATE SIGNED

REPORT OF CASUALTY		REPORT CONTROL SYMBOL DD-P&R(AR)1664			
		1. REPORT TYPE		2. DATE PREPARED	
3. SERVICE IDENTIFICATION					
a. NAME (Last, First, Middle and Suffix)		b. SOCIAL SECURITY NO.	c. RANK	d. PAY GRADE	e. OCCUPATIONAL CODE/ RATING
f. COMPONENT	g. BRANCH	h. ORGANIZATION			
4. CASUALTY INFORMATION					
a. TYPE	b. STATUS	c. CATEGORY	d. DATE OF CASUALTY	e. PLACE OF CASUALTY	
f. CIRCUMSTANCES					
g. DUTY STATUS				h. BODY RECOVERED	
5. BACKGROUND INFORMATION					
a. DATE OF BIRTH	b. PLACE OF BIRTH		c. COUNTRY OF CITIZENSHIP		
d. RACE					
e. ETHNICITY				f. SEX	
g. RELIGIOUS PREFERENCE					
6. ACTIVE DUTY INFORMATION					
a. PLACE OF ENTRY	b. DATE OF ENTRY	c. HOME OF RECORD AT TIME OF ENTRY			
7. INTERESTED PERSONS/REMARKS (Name, Address, and Relationship) (Continue on separate sheet, if necessary)					
<p>FOOTNOTES: 1 Adult next of kin. 2 Beneficiary for gratuity pay in event there is no surviving spouse or child - as designated on record of emergency data. 3 Beneficiary for unpaid pay and allowances - as designated on record of emergency data.</p>					
8. REPORTING INFORMATION					
a. COMMAND AGENCY				b. DATE RECEIVED	
9. DISTRIBUTION		10. SIGNATURE ELEMENT			
NOTE: This form may be used to facilitate the cashing of bonds, the payment of commercial insurance, or in the settlement of any other claim in which proof of death is required.					

APPLICATION FOR IDENTIFICATION CARD/DEERS ENROLLMENT										OMB No. 0704-0415 OMB approval expires Jan 31, 2014		
Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions prior to completing this form.												
SECTION I - SPONSOR/EMPLOYEE INFORMATION												
1. NAME (Last, First, Middle)				2. GENDER	3. SSN OR DOD ID NO.		4. STATUS		5. ORGANIZATION			
6. PAY GRADE		7. GEN. CAT		8. CITIZENSHIP		9. DATE OF BIRTH (YYYYMMDD)		10. PLACE OF BIRTH				
11. CURRENT HOME ADDRESS					12. CITY		13. STATE	14. ZIP CODE		15. COUNTRY		
16. PRIMARY E-MAIL ADDRESS				17. TELEPHONE NUMBER (Include Area Code/DSN)		18. CITY OF DUTY LOCATION		19. STATE OF DUTY LOCATION		20. COUNTRY OF DUTY LOCATION		
SECTION II - SPONSOR/EMPLOYEE DECLARATION AND REMARKS												
21. REMARKS (Cite legal documentation, as applicable.)										NOTARY SIGNATURE AND SEAL		
I certify the information provided in connection with the eligibility requirements of this form is true and accurate to the best of my knowledge. (If not signed in the presence of the authorizing/verifying official, the signature must be notarized.)												
22. SPONSOR/EMPLOYEE SIGNATURE								23. DATE SIGNED (YYYYMMDD)				
SECTION III - AUTHORIZED BY												
24. SPONSORING OFFICE NAME								25. CONTRACT NUMBER				
26. SPONSORING OFFICE ADDRESS (Street, City, State, ZIP Code)				27. SPONSORING OFFICE TELEPHONE NUMBER (Include Area Code/DSN)		28. OFFICE EMAIL ADDRESS			29. OVERSEAS ASSIGNMENT (Country)			
30. OVERSEAS ASSIGNMENT BEGIN DATE (YYYYMMDD)			31. OVERSEAS ASSIGNMENT END DATE (YYYYMMDD)			32. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)		33. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)				
I certify the individual identified above, based on personal knowledge and available documentation, is in a status eligible for and requires an identification card in the performance of their duties with the Uniformed Services.												
34. SPONSORING OFFICIAL NAME (Last, First, Middle)					35. UNIT/ORGANIZATION NAME							
36. TITLE			37. PAY GRADE		38. SIGNATURE				39. DATE VERIFIED (YYYYMMDD)			
SECTION IV - DEPENDENT INFORMATION (Attach additional pages if necessary)												
A	40. NAME (Last, First, Middle)				41. GENDER	42. DATE OF BIRTH (YYYYMMDD)		43. RELATIONSHIP		44. SSN OR DOD ID NO.		
	45. CURRENT HOME ADDRESS											
	46. CITY			47. STATE		48. ZIP CODE		49. COUNTRY		50. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)		51. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)
B	52. NAME (Last, First, Middle)				53. GENDER	54. DATE OF BIRTH (YYYYMMDD)		55. RELATIONSHIP		56. SSN OR DOD ID NO.		
	57. CURRENT HOME ADDRESS											
	58. CITY			59. STATE		60. ZIP CODE		61. COUNTRY		62. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)		63. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)
SECTION V - RECEIPT												
Receipt of new card is acknowledged.												
64. SIGNATURE								65. DATE ISSUED (YYYYMMDD)				

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0415). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION.
RETURN COMPLETED FORM TO A REAL-TIME AUTOMATED PERSONNEL IDENTIFICATION SYSTEM WORK STATION.**

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Section 301; 10 U.S.C. chapter 147; 10 U.S.C. Sections 1061 - 1065, 1072 - 1074, 1074a - 1074c, 1074c(1), 1076, 1076a, 1077, 1095(k)(2); 50 U.S.C. chapter 23; E.O. 9397; E.O. 10450, as amended.

PRINCIPAL PURPOSE(S): To apply for and enroll in the Defense Enrollment Eligibility Reporting System (DEERS) for DoD benefits and privileges. These benefits and privileges include, but are not limited to, medical coverage, DoD Identification Cards, access to DoD installations, buildings or facilities, and access to DoD computer systems and networks.

ROUTINE USE(S): To Federal and State agencies and private entities; individual providers of care, and others, on matters relating to claim adjudication, program abuse, utilization review; professional quality assurance; medical peer review, program integrity, third party liability, coordination of benefits and civil and criminal litigation, and access to Federal government and contractor facilities, computer systems, networks, and controlled areas. The DD Form 1172-2 currently covers the RUs that would include retirees and dependents. To the Department of Health and Human Services, the Department of Veterans Affairs, the Social Security Administration, and to other Federal, state, and local government agencies to identify individuals having benefit eligibility in another plan or program. For a complete list of DEERS routine uses, visit: <http://privacy.defense.gov/notices/osd/DMDC02.shtml>.

Applicant information is subject to computer matching within the Department of Defense or with other Federal or non-Federal agencies. Matching programs are conducted to assure that an individual eligible under a Federal program is not improperly receiving duplicate benefits from another program. A beneficiary or former beneficiary who has applied for privileges of a Federal Benefit Program and has received concurrent assistance under another plan will be subject to adjustment or recovery of any improper payments made or delinquent debts owed.

DISCLOSURE: Voluntary; however, failure to provide information may result in denial of a Uniformed Services Identification Card and/or non-enrollment in the Defense Enrollment Eligibility Reporting System, refusal to grant access to DoD installations, buildings, facilities, computer systems and networks.

Penalty for presenting false claims or making false statements in connection with claims: fine of up to \$10,000 or imprisonment for up to five years or both.

INSTRUCTIONS

The instructions for completing the DD Form 1172-2 should be closely followed to ensure accurate data collection and to preclude overcollection of information. Section IV of this form should only be completed if benefits or sponsorship is being requested for/by an eligible sponsor or their dependent. Instructions for the DD Form 1172-2 can be found at: <http://www.cac.mil/docs/1172-2-Instructions.pdf>

APPLICATION FOR IDENTIFICATION CARD/DEERS ENROLLMENT
Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions prior to completing this form.

OMB No. 0704-0415
OMB approval expires
Jan 31, 2014

SECTION I - SPONSOR/EMPLOYEE INFORMATION

1. NAME (Last, First, Middle)		2. GENDER	3. SSN OR DOD ID NO.	4. STATUS	5. ORGANIZATION
6. PAY GRADE	7. GEN. CAT	8. CITIZENSHIP	9. DATE OF BIRTH (YYYYMMDD)	10. PLACE OF BIRTH	
11. CURRENT HOME ADDRESS			12. CITY	13. STATE	14. ZIP CODE
16. PRIMARY E-MAIL ADDRESS		17. TELEPHONE NUMBER (Include Area Code/DSN)	18. CITY OF DUTY LOCATION	19. STATE OF DUTY LOCATION	20. COUNTRY OF DUTY LOCATION

SECTION II - SPONSOR/EMPLOYEE DECLARATION AND REMARKS

21. REMARKS (Cite legal documentation, as applicable.)	NOTARY SIGNATURE AND SEAL
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I certify the information provided in connection with the eligibility requirements of this form is true and accurate to the best of my knowledge. (If not signed in the presence of the authorizing/verifying official, the signature must be notarized.)

22. SPONSOR/EMPLOYEE SIGNATURE	23. DATE SIGNED (YYYYMMDD)
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SECTION III - AUTHORIZED BY

24. SPONSORING OFFICE NAME			25. CONTRACT NUMBER		
26. SPONSORING OFFICE ADDRESS (Street, City, State, ZIP Code)		27. SPONSORING OFFICE TELEPHONE NUMBER (Include Area Code/DSN)	28. OFFICE EMAIL ADDRESS		29. OVERSEAS ASSIGNMENT (Country)
30. OVERSEAS ASSIGNMENT BEGIN DATE (YYYYMMDD)	31. OVERSEAS ASSIGNMENT END DATE (YYYYMMDD)	32. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)	33. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)		

I certify the individual identified above, based on personal knowledge and available documentation, is in a status eligible for and requires an identification card in the performance of their duties with the Uniformed Services.

34. SPONSORING OFFICIAL NAME (Last, First, Middle)		35. UNIT/ORGANIZATION NAME			
36. TITLE	37. PAY GRADE	38. SIGNATURE		39. DATE VERIFIED (YYYYMMDD)	

SECTION IV - DEPENDENT INFORMATION (Attach additional pages if necessary)

A	40. NAME (Last, First, Middle)		41. GENDER	42. DATE OF BIRTH (YYYYMMDD)	43. RELATIONSHIP	44. SSN OR DOD ID NO.
	45. CURRENT HOME ADDRESS					
	46. CITY	47. STATE	48. ZIP CODE	49. COUNTRY	50. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)	51. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)

B	52. NAME (Last, First, Middle)		53. GENDER	54. DATE OF BIRTH (YYYYMMDD)	55. RELATIONSHIP	56. SSN OR DOD ID NO.
	57. CURRENT HOME ADDRESS					
	58. CITY	59. STATE	60. ZIP CODE	61. COUNTRY	62. ELIGIBILITY EFFECTIVE DATE (YYYYMMDD)	63. ELIGIBILITY EXPIRATION DATE (YYYYMMDD)

SECTION V - RECEIPT

Receipt of new card is acknowledged.	
64. SIGNATURE	65. DATE ISSUED (YYYYMMDD)

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DEPARTMENT OF VETERANS AFFAIRS
Regional Office and Insurance Center
P.O. Box 8079
Philadelphia, PA 19101

We are truly sorry for your loss. We know this is a most difficult time in your life, but we want to provide you with the options that are available for you to receive your life insurance payment. Unless the insured designated otherwise, you have four options:

Option A: Alliance Account

This is an account opened for you by the program's primary insurer, The Prudential Insurance Company of America. This account earns interest, and you would be sent a book of drafts (similar to a checkbook). You then have the choice of writing a draft for the entire balance in your account, or you could use drafts to pay any immediate bills and leave the balance in the Alliance Account until you have the opportunity to consider permanent alternatives.

The Alliance Account is not a bank account and is not insured by the FDIC. The Alliance Account is a contractual obligation of Prudential and backed by the financial strength of the company. While the account is not insured by the FDIC, every state has a state guaranty association that is legally obligated to guaranty payment of at least \$250,000, with most states providing \$300,000 in protection, and a few providing protection of up to \$500,000. These associations have met all obligations since they were created 25 years ago.

If you do not decide on a way to receive your insurance payment, you will automatically receive the funds in an Alliance Account.

Option B: Check Mailed to You

A check for the full amount due will be mailed in your name to the address you enter on the Claim for Death Benefits.

Option C: Electronic Funds Transfer

The full amount due will be transferred to the bank account you provide on the Claim for Death Benefits.

Option D: 36 Equal Monthly Installments

You would receive a check each month for the insurance, plus interest, over a period of 36 months.

We strongly urge you to take advantage of the free, independent, third party financial counseling offered through **Beneficiary Financial Counseling Service**. For more information about the counseling service call FinancialPoint® at 1-888-243-7351.

The Casualty Officer assisting you will be able to answer any questions you have, and will help you complete the claim form. If you have questions at a later date please call the Office of Servicemembers' Group Life Insurance at 1-800-419-1473.

Again, please accept our condolences on your loss.

Sincerely,

Department of Veterans Affairs

Ed. 06/2011



Prudential

Office of Servicemembers'
Group Life Insurance

OSGLI USE ONLY	CLAIM FOR DEATH BENEFITS Servicemembers' Group Life Insurance Veterans' Group Life Insurance	RETURN COMPLETED FORM TO:	The Prudential Insurance Company of America Office of Servicemembers' Group Life Insurance 80 Livingston Avenue Roseland, NJ 07068-1733
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Note: This form is not to be used for National Service Life Insurance (NSLI) Policy Numbers Prefixed by V, H, RH, RS, W, J, JR and JS or United States Government Life Insurance (USGLI) Policy Numbers Prefixed by K

READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM

1. Name of deceased (first middle last)	2. Social Security Number	3. Date of death
4. Branch of service	5. Duty status on date of death (if known) <input type="checkbox"/> Active Duty <input type="checkbox"/> Discharged or Separated <input type="checkbox"/> Drilling Reservist <input type="checkbox"/> Individual Reservist Ready	6. If discharged or separated, give date (if known) (month day year)

PART I - Claimant Information

7. Your name (first middle last)	8. Your relationship to the deceased	9. Your date of birth (month day year)	10. Your Social Security Number
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If you are the widow or widower of deceased complete Items 11A through 14C

11A. Date of marriage (month day year)	11B. Place of marriage (City & State)	12. Did the marriage continue until date of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
13A. Did deceased have any previous marriages? (If yes, complete 13B & 13C) <input type="checkbox"/> Yes <input type="checkbox"/> No	13B. Previous marriage terminated by: <input type="checkbox"/> Death <input type="checkbox"/> Divorce	13C. Date previous marriage terminated (if divorced within last 5 years, attach copy of the divorce decree).
14A. Did you have any previous marriages? (If yes, complete 14B & 14C) <input type="checkbox"/> Yes <input type="checkbox"/> No	14B. Previous marriage terminated by: <input type="checkbox"/> Death <input type="checkbox"/> Divorce	14C. Date previous marriage terminated (if divorced within last 5 years, attach copy of the divorce decree).

PART II - Information concerning the next of kin of the deceased

If you are not the named beneficiary, widow, or widower of the deceased, complete Parts II and III

In the table below, list the name, age, relationship, and address of:

- (a) Widow or widower None If none, was insured ever married? Yes No
If Yes, did marriage terminate by: Divorce (mm dd yyyy) _____ Death (mm dd yyyy) _____
- (b) If there is no surviving widow or widower, list all the children of the deceased. Include any adopted child or illegitimate child and indicate each child's status. List the descendants of any deceased child or children. If no children, check box:
- (c) If there are no children or descendants of children, list the surviving parent or parents.
Is the father deceased? Yes No Is the mother deceased? Yes No
- (d) If there are no survivors within the degrees indicated in (a) through (c), list below the next of kin who may be capable of inheriting from the deceased (brothers, sisters, descendants of deceased brothers or sisters, etc.).

15A. Name	15B. Age	15C. Relationship to deceased	15D. Address

Complete items 16 and 17 ONLY if any of the persons listed above are under the age of 21.

16. Name and address of guardian for any minor children listed above if one has been appointed by the court. (Attach copy of appointment paper issued by court.)	17. If a guardian has not been appointed, will one be appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--



Prudential

Office of Servicemembers'
Group Life Insurance

Name of Deceased:

SSN of Deceased:

PART III - Information concerning the estate of the deceased

18. Name and address of the executor or administrator, if any, appointed by the court to settle the estate of the deceased.

19. If an executor has not been appointed, will one be appointed?
 Yes No

PART IV - Method of Payment

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. In the event the insured has not previously elected 36 monthly installments, my preferred method of payment is:

- Lump Sum – Alliance Account®
- Lump Sum – Check
- Lump Sum – Electronic Funds Transfer (EFT) – Please complete your banking information below.
- 36 equal monthly payments

Payment will be made by the Alliance Account® if no option is selected.

For EFT only – Please provide your banking information below to have the benefit paid by Electronic Funds Transfer.

Bank Routing Number Bank Account Number Checking
 Savings

Bank Name Bank Phone Number

First Name MI Last Name

The bank routing number is always 9 digits and appears between the ⑈ symbols

Customer's Name
Street Address
City, State, Zip

Sample Check

PAY TO THE ORDER OF _____ \$ Dollars

Check No. 1234

Bank Name
Street Address
City, State, Zip

⑈ 223207349 ⑈ 00123012201234 ⑈ 1234

The bank account number varies in length and may contain dashes or spaces. The ⑈ symbol indicates the end of the account number.

Bank Routing Number Bank Account Number Check Number (not needed)

If I have selected payment by Electronic Funds Transfer, I authorize The Prudential Insurance Company of America to make an electronic fund deposit to my account. I understand that any deposit made to an inactive account will be returned to Prudential and issued as a manual check.

Open Solutions Inc. is the Service Provider of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc., JPMorgan Chase Bank, N.A., and First Data Payment Services are not Prudential Financial companies.



Prudential

Office of Servicemembers'
Group Life Insurance

Name of Deceased:

SSN of Deceased:

PART V - Certification by claimant

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.

20. Signature of claimant (Do not print)

21. Address (Number and Street, Apt. No., City, State, ZIP Code)

22. Date

23. Phone

WARNING — Any intentionally 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)



Prudential

Office of Servicemembers'
Group Life Insurance

INSTRUCTIONS TO CLAIMANTS *

THIS FORM SHOULD BE USED WHEN THE DECEASED HAD INSURANCE IN FORCE UNDER SERVICEMEMBERS' GROUP LIFE INSURANCE (SGLI) OR VETERANS' GROUP LIFE INSURANCE (VGLI).

PAYMENT OF DEATH BENEFITS

Under SGLI and VGLI death benefit payments must be made in the following order:

- To the beneficiary named in writing by the insured; if none, the insurance is payable to
- the widow or widower of the insured; if none, it is payable to
- the child or children in equal shares with the share of any deceased child distributed among the descendants of that child; if none, it is payable to
- parent(s) in equal shares; if none, it is payable to
- a duly appointed executor or administrator of the insured's estate, and if none, to
- other next of kin.

COMPLETION OF CLAIM FOR DEATH BENEFITS

It is important that all requested information be furnished. Omission or incomplete answers will delay settlement of the claim. All information should be typed or printed in ink, except the signature.

- | | |
|-------------------------|--|
| Item 1 | Show full name of the deceased service member or Veteran. |
| Item 2 | Show Social Security Number of deceased. If the deceased did not have a Social Security Number show service number. |
| Item 3 | Show date of death of deceased. |
| Items 4, 5
and 6 | Show branch of service, duty status on date of death (if known), and date of discharge or separation (if known) of deceased. |
| Items 7, 8,
9 and 10 | Show your full name, relationship to deceased, your date of birth, and Social Security Number. |

If you were married to the deceased when he/she died, but were not named as his/her insurance beneficiary, complete items 11A through 14C as applicable.

If you were not married to the deceased when he/she died and were not specifically named as his/her insurance beneficiary, complete Part II through 15D. Be sure to provide the required information as to the deceased's marital status and any children. In items 15A through 15D give the information about persons indicated in the answers to the preceding questions. Use a separate signed sheet if necessary.

Complete Part III if you were not named as the insurance beneficiary, were not married to the deceased at his/her death and are not a parent of the deceased.

Part IV must be completed by all claimants.

* Contact your nearest Department of Veterans Affairs Office if you need assistance with completing this claim form.



Prudential

Office of Servicemembers'
Group Life Insurance

EVIDENCE REQUIRED

If the deceased died while on active duty, or while a member of a Reserve or National Guard Unit, the Office of Servicemembers' Group Life Insurance will be furnished with proof of death by the Uniformed Service. In all other situations, the claimant must submit a certified copy of the Certificate of Death.

Members performing duty on a full-time basis, usually over 30 days, and qualified members of the Ready Reserve are insured for 120 days following separation. Members totally disabled at separation may be insured for up to two years following separation as long as total disability continues. If the insured died while covered following separation from service, the claimant must also submit a copy of a report of separation, DD 214.

You will be informed if it becomes necessary to submit other evidence.

ABOUT THE ALLIANCE ACCOUNT

1. The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily, and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.
2. The interest rate credited to the Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short term demand deposit accounts, bank money market rates and Federal Reserve Interest rates) and may be more or less than the rate Prudential earns on the funds in the account.
3. An Alliance Account is an interest bearing draft account established in the beneficiary's name with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.
4. **The funds in your Alliance Account are available immediately.** Simply use the enclosed drafts ("checks") to access the account anytime you wish. You can write a check to yourself (which you can cash or deposit at your own bank) or write a check to another person or to any business as you need your funds.
5. Alliance Account funds are part of Prudential's General Account and are backed by the financial strength of The Prudential Insurance Company of America which has been in business and serving its customers for over 130 years. **The Alliance Account is not a bank account or a bank product, and therefore, is not FDIC insured.**
6. Accountholders cannot make deposits into an Alliance Account. Only eligible payments from other Prudential insurance policies or contracts may be added to the Alliance Account.
7. You can access the money immediately by using the draft book ("check book") you will receive. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.

Open Solutions Inc. is the Service Provider of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by First Data Payment Services (FDPS). **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** Open Solutions Inc., JPMorgan Chase Bank, N.A., and First Data Payment Services are not Prudential Financial companies.



Prudential

**Office of Servicemembers'
Group Life Insurance**

SERVICEMEMBERS' GROUP LIFE INSURANCE TRAUMATIC INJURY PROTECTION PROGRAM (TSGLI)

Administered by the Office of Servicemembers' Group Life Insurance

Application for TSGLI Benefits

Please submit your completed claim to your branch of service below.

TSGLI Branch of Service Contacts				
Branch	Contact Information	Submit Claim by Fax	Submit Claim by E-mail	Submit Claim by Postal Mail
Army All Components	Phone: (800) 237-1336 Website: www.tsqli.army.mil	(502) 613-4513	tsqli.claims@conus.army.mil	United States Army Human Resources Command ATTN: AHRC-PDP-V 1600 Spearhead Division Avenue Dept 480 Fort Knox, KY 40122
Marine Corps All Components	Phone: (877) 216-0825 or (703) 432-9277 Website: www.woundedwarriorregiment.org	(888) 858-2315	t-sqli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Avenue Quantico, VA 22134
Navy All Components	Phone: (800) 368-3202 (option 5) or (901) 874-6662 DSN 882 Website: www.npc.navy.mil/Command Support/CasualtyAssistance/TSGLI	(901) 874-2265	MILL_TSGLI@navy.mil	Office of the Chief of Naval Operations Attn: OPNAV N135C 5720 Integrity Drive Millington, TN 38055-6200
Air Force Active Duty	Phone: (800) 433-0048 Website: www.afpc.af.mil	(210) 565-2348	afpc.casualty@us.af.mil	AFPC/DPWCS 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
Air Force Reserves	Phone: (800) 525-0102	(720) 847-3895	casualty.arpc@arpc.denver.af.mil	HQ, ARPC/DPTTE Building 390 MS68 18420 E. Silver Creek Ave. Buckley AFB, CO 80011
Air National Guard	Phone: (240) 612-9072		nbg.a1ps@ang.af.mil	NCOIC, Customer Operations NGB/A1PS 3500 Fetchet Ave. 2nd Floor Joint Base Andrews, MD 20762
Coast Guard	Phone: (202) 493-1931 or (202) 493-1935 Website: www.uscg.mil/psc/psd/fs/TSGLI.asp	(202) 493-1939	ARL-PF-CGPSC-PSDFS- COMPENSATION@uscg.mil	Commander (PSD FS - Casualty) U.S. Coast Guard Personnel Service Center 4200 Wilson Blvd., Suite 1100, MAIL STOP 7200 Arlington, VA 20598-7200
Public Health Services	Phone: (301) 427-3280	(301) 427-3431 or (301) 427-3432	compensationbranch@psc.hhs.gov	PHS Compensation Branch 8455 Colesville Rd, Rm 935 Silver Spring, MD 20910
NOAA Corps	Phone: (301) 713-3444	(301) 713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce NOAA/OMAO/CPC 8403 Colesville Rd, Suite 500 Silver Spring, MD 20910

SGLV 8600
(Supersedes SGLV 8600 Ed. 12/2011)
GL.2005.261 Ed. 01/2012



GENERAL INFORMATION

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program provides for payment to service members who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured service members and their families with financial burdens associated with recovering from a severe injury. TSGLI payments range from \$25,000 to \$100,000 based on the qualifying loss suffered.

WHO IS ELIGIBLE?

Effective December 1, 2005, all service members who are insured under SGLI and ...

- experience a **traumatic event**
- that results in a **traumatic injury**
- which is listed as a **qualifying loss**

are eligible to receive a TSGLI payment. Service members who were severely injured between October 7, 2001 and November 30, 2005 may also be eligible for a TSGLI payment, regardless of where their injury occurred or whether they had SGLI coverage at the time of their injury. Members should contact their branch of service for more information.

What is a Traumatic Event?

A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

What is a Traumatic Injury?

A traumatic injury is the physical damage to your body that results from a traumatic event.

What is a Qualifying Loss?

A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses, which lists all covered losses and payment amounts. You may view the complete Schedule of Losses and other TSGLI information at www.insurance.va.gov/sgliSite/TSGLI.htm Your branch of service TSGLI office will determine whether your injury is a qualifying loss for TSGLI purposes.

HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three-step process in which the service member [or guardian, power of attorney or military trustee] and a medical professional must complete and submit the appropriate parts of the TSGLI Claim Form as follows:

Step 1	Step 2	Step 3
The service member [or guardian, power of attorney or military trustee]...	The medical professional...	The medical professional OR the service member [or guardian, power of attorney or military trustee]...
must complete Part A (pages 3 through 7) of the form and give it to a medical professional to complete Part B. Note: If a guardian or power of attorney completes Part A, they must include copies of letters of guardianship, letters of conservatorship, power of attorney, or durable power of attorney (if appropriate).	must complete Part B.	must forward Parts A & B, along with medical records that document the member's injury and resulting loss, to the member's branch of service TSGLI office listed on the front cover of this form.

COMPLETING THE FORM

Instructions on completing the TSGLI Claim Form are included in each section. When completing the form, the service member, guardian, power of attorney or military trustee **must** complete the service member's Social Security number on each page of the form. If you have questions about completing the form or if the member is deceased, please contact the branch of service TSGLI office listed on the front cover of this form.

CLAIM DECISION AND PAYMENT

Who Makes the Decision on My Claim?

Your branch of service TSGLI office will make the decision on your claim based upon the information in Parts A and B of the TSGLI Claim Form and any supporting medical documentation you provide. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.



Who Will Receive the TSGLI Payment?

Payment will be made directly to the member. If the member is incompetent, payment will be made under the appropriate letters of guardianship/ conservatorship or a power of attorney to the guardian, power of attorney or military trustee on the member's behalf. If the member dies after qualifying for payment, the payment will be made to the member's current listed SGLI beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

How the TSGLI Payment Will be Made?

If your branch of service TSGLI office approves your claim, OSGLI will make the TSGLI benefit payment. There are three payment methods used for TSGLI benefits: Prudential's Alliance Account®*, Electronic Funds Transfer (EFT), or check. If you do not choose a payment option, OSGLI will make the payment through Prudential's Alliance Account®.

1. Prudential's Alliance Account®* —

- 1) The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.
- 2) The interest rate credited to the Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short term demand deposit accounts, bank money market rates and Federal Reserve Interest rates) and may be more or less than the rate Prudential earns on the funds in the account.
- 3) An Alliance Account is an interest bearing draft account established in the beneficiary's name with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.
- 4) **The funds in your Alliance Account are available immediately.** Use the drafts ("checks") to access the account anytime you wish. You can write a check to yourself (which you can cash or deposit at your own bank) or write a check to another person or to any business as you need your funds.
- 5) Alliance Account funds are part of Prudential's General Account and are backed by the financial strength of The Prudential Insurance Company of America which has been in business and serving its customers for over 130 years. The Alliance Account is not a bank account or a bank product, and therefore, is not FDIC insured.
- 6) Accountholders cannot make deposits into an Alliance Account. Only eligible payments from other Prudential insurance policies or contracts may be added to the Alliance Account.

Note: A service member's legal guardian, military trustee, or power of attorney (POA) may choose the Alliance Account payment option as long as they submit proof of that appointment (i.e. the appropriate documentation) with the claim. The guardian, military trustee, or POA will not have their name added to the account, but will be able to sign Alliance Account checks on behalf of the member.

2. **Electronic Funds Transfer (EFT)** — Your bank account will be electronically credited with the TSGLI payment amount. Depending on your bank, payments will be credited three to five days from the date the payment is authorized.
3. **Check Payment** — A check will be issued to the service member, guardian, power of attorney or military trustee on behalf of the member.

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PART A - Member's Claim Information and Authorization (cont'd) - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security Number

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3 Traumatic Injury Information

Information About Your Loss

Is the loss you are claiming the result of any of the following:

- a. an intentionally self-inflicted injury or an attempt to inflict such injury? Yes No
- b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor? Yes No
- c. the medical or surgical treatment of an illness or disease? Yes No
- d. a traumatic injury sustained while committing or attempting to commit a felony? Yes No
- e. a physical or mental illness or disease (not including illness or disease caused by a wound infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance)? Yes No

If you answered yes...

to any of the questions above, you are not eligible for a TSGLI payment and should not file a claim.

If you are not sure...

whether your loss is a result of one of the items above, please contact your Branch of Service TSGLI Office to find out if you are eligible.

Tell us about your traumatic injury

In the box below, please describe your injury and give the date, time and location where it occurred. **You must also submit medical records with this claim that document your injuries and resulting loss. (See Part B for qualifying losses.)**

Traumatic Injury Information



PART A - Member's Claim Information and Authorization (cont'd) - to be completed by the member, guardian, power of attorney or military trustee.

Service member's Social Security Number

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6 Signature

X

Signature of service member, guardian, power of attorney or military trustee Date (MM DD YYYY)

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Description of Authority to act on behalf of the member (Guardian, POA, etc.)

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)

Description of Authority: If the guardian, power of attorney or military trustee completes this section, they must also indicate their authority to act on behalf of the member (e.g. guardian, conservator, etc.)

Member must complete and sign the HIPAA release on page 7



PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd)

Loss of Hearing

- Loss of hearing in left ear
- Loss of hearing in right ear

Date of onset

Loss of hearing is defined as:

Average hearing threshold sensitivity for air conduction of at least 80 decibels. Hearing Acuity must be measured at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing threshold. Loss of hearing must be clinically stable and unlikely to improve.

Hearing Acuity

Average Hearing Acuity (measured without amplification device)

Left Ear

Right Ear

db					db				

Burns

- 2nd degree or worse burns to the body including face and head
- 2nd degree or worse burns to the face only

Burns are defined as:

2nd degree (partial thickness) or worse burns over 20% of the body including the face and head OR 20% of the face only.

Percentage of body affected %

Percentage of face affected %

Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative.

Coma

- Coma

Date of onset

Date of recovery

Coma is defined as:

Coma with brain injury measured at a Glasgow Coma Score of 8 or less that lasts for 15, 30, 60 or 90 consecutive days.

Number of days includes the date the coma began and the date the member recovered from the coma.

OR Check here if coma is ongoing

Glasgow score at 15 days Glasgow score at 30 days Glasgow score at 60 days Glasgow score at 90 days

Important:

Facial Reconstruction:

If the patient is undergoing facial reconstruction, a surgeon MUST certify this section by checking the box, printing his/her name and signing on the appropriate line.

Facial Reconstruction

- | | |
|--|--|
| <input type="checkbox"/> Upper or lower jaw | <input type="checkbox"/> 50% of left zygomatic |
| <input type="checkbox"/> 50% of cartilaginous nose | <input type="checkbox"/> 50% of right zygomatic |
| <input type="checkbox"/> 50% of upper lip | <input type="checkbox"/> 50% of left mandibular |
| <input type="checkbox"/> 50% of lower lip | <input type="checkbox"/> 50% of right mandibular |
| <input type="checkbox"/> 30% of left periorbital | <input type="checkbox"/> 50% of left infraorbital |
| <input type="checkbox"/> 30% of right periorbital | <input type="checkbox"/> 50% of right infraorbital |
| <input type="checkbox"/> 50% of left temple | <input type="checkbox"/> 50% of chin |
| <input type="checkbox"/> 50% of right temple | <input type="checkbox"/> 50% of forehead |

Facial Reconstruction is defined as:

Reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects, specifically surgery to correct discontinuity loss of the following:

- upper or lower jaw
- 50% or more of the cartilaginous nose
- 50% or more of the upper or lower lip
- 30% or more of the periorbital
- tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin.

Certification of Surgeon

Date of first surgery

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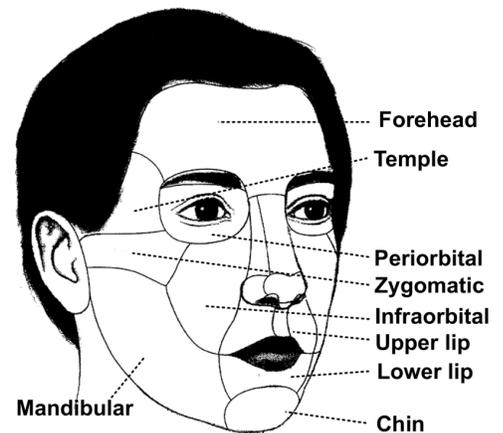
Name of Surgeon

X

Signature of Surgeon

Date (MM DD YYYY)

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PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd)

Amputation is: the severance or removal of a limb or genital organ or part of a limb or genital organ, including both severance due to a traumatic injury, or surgical removal that is required for the treatment of a traumatic injury.

Amputation of Hand

- Amputation of left hand
- Amputation of right hand

Date of amputation

Amputation of Hand is defined as:

Amputation of hand at or above the wrist
Above the wrist means closer to the body.

Amputation of Fingers

- Amputation of 4 fingers/ left hand
- Amputation of 4 fingers/ right hand
- Amputation of left thumb
- Amputation of right thumb

Date of amputation

Amputation of Fingers is defined as:

- Amputation of four fingers on the same hand (not including the thumb) at or above the metacarpophalangeal joint OR,
- Amputation of thumb at or above the metacarpophalangeal joint.

Above the metacarpophalangeal joint means closer to the body.

Amputation of Foot

- Amputation of left foot
- Amputation of right foot

Date of amputation

Amputation of Foot is defined as:

- Amputation of foot at or above the ankle OR,
- Amputation of all toes (including the big toe) on the same foot at or above the metatarsophalangeal joint.

Above the ankle and above the metatarsophalangeal joint means closer to the body.

Amputation of Toes

- Amputation of 4 toes/ left foot
- Amputation of 4 toes/ right foot
- Amputation of big toe/ left foot
- Amputation of big toe/ right foot

Date of amputation

Amputation of Toes is defined as:

- Amputation of four toes on one foot at or above the metatarsophalangeal joint (not including the big toe) OR,
- Amputation of big toe at or above the metatarsophalangeal joint.

Above the metatarsophalangeal joint means closer to the body.

Important:

Limb Salvage:
If the patient is undergoing limb salvage, a surgeon MUST certify this section by printing his/her name and signing on the appropriate line.

Limb Salvage

- Salvage of left arm
- Salvage of left leg
- Salvage of right arm
- Salvage of right leg

Date of first surgery

Limb Salvage is defined as:

A series of operations designed to avoid amputation of an arm or a leg while at the same time maximizing the limb's functionality. The surgeries typically involve bone and skin grafts, bone resection, reconstructive, and plastic surgeries and often occur over a period of months or years.

Submit operative report for each surgery.

Certification of Surgeon

I certify that the patient is undergoing limb salvage surgery as defined in the column to the right.

Name of Surgeon

Specialty

X

Signature of Surgeon

Additional Comments

Date (MM DD YYYY)

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PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd)

Paralysis	Date of onset
<input type="checkbox"/> Quadriplegia	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Paraplegia	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Hemiplegia	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Uniplegia	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Paralysis is defined as:

Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain. A limb is defined as an arm or a leg with all its parts. Paralysis must fall into one of the four categories listed below:

- Quadriplegia - paralysis of all four limbs
- Paraplegia - paralysis of both lower limbs
- Hemiplegia - paralysis of the upper and lower limbs on one side of the body
- Uniplegia - paralysis of one limb

Genitourinary System Losses

<input type="checkbox"/> Anatomical loss of the penis	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of the penis is defined as:

Amputation of the glans penis or any portion of the shaft of the penis above the glans penis or damage to the glans penis or shaft of the penis that requires reconstructive surgery.

Above the glans penis means closer to the body.

<input type="checkbox"/> Permanent loss of use of the penis	Date of loss
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Permanent loss of use of the penis is defined as:

Damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

<input type="checkbox"/> Anatomical loss of one testicle	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of one testicle is defined as:

The amputation of, or damage to, one testicle that requires testicular salvage, reconstructive surgery, or both.

<input type="checkbox"/> Anatomical loss of both testicles	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of both testicle(s) is defined as:

The amputation of, or damage to, both testicles that requires testicular salvage, reconstructive surgery, or both.

<input type="checkbox"/> Permanent loss of use of both testicles	Date of loss
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Permanent loss of use of both testicles is defined as:

Damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

<input type="checkbox"/> Anatomical loss of the vulva	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of the vulva is defined as:

The complete or partial amputation of the vulva or damage to the vulva that requires reconstructive surgery.

<input type="checkbox"/> Anatomical loss of the uterus	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of the uterus is defined as:

The complete or partial amputation of the uterus or damage to the uterus that requires reconstructive surgery.

<input type="checkbox"/> Anatomical loss of the vaginal canal	Date of loss or amputation
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Anatomical loss of the vaginal canal is defined as:

The complete or partial amputation of the vaginal canal or damage to the vaginal canal that requires reconstructive surgery.

<input type="checkbox"/> Permanent loss of use of the vulva	Date of loss
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Permanent loss of use of the vulva is defined as:

Damage to the vulva that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

<input type="checkbox"/> Permanent loss of use of the vaginal canal	Date of loss
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Permanent loss of use of the vaginal canal is defined as:

Damage to the vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.



PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd)

<input type="checkbox"/> Anatomical loss of one ovary	Date of loss or amputation <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>							Anatomical loss of the ovary is defined as: The amputation of one ovary or damage to one ovary that requires ovarian salvage, reconstructive surgery, or both.
<input type="checkbox"/> Anatomical loss of both ovaries	Date of loss or amputation <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>							Anatomical loss of both ovaries is defined as: The amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both.
<input type="checkbox"/> Permanent loss of use of both ovaries	Date of loss <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>							Permanent loss of use of both ovaries is defined as: Damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.
<input type="checkbox"/> Total and permanent loss of urinary system function	Date of loss <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>							Total and permanent loss of urinary system function is defined as: Damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.

Description of Injury/ Assistance Needed
Please provide a description of the injury and descriptions of the assistance needed to perform each ADL. Failure to provide this information may delay payment of claim.

Inability to Independently Perform Activities of Daily Living (ADL)

Inability to Independently Perform ADL is defined as: Inability to independently perform at least two of six ADL (bathing, continence, dressing, eating, toileting and transferring). Inability must last for at least 15 consecutive days for traumatic brain injury and at least 30 consecutive days for any other traumatic injury.

The patient is considered unable to perform an activity independently only if he or she **REQUIRES** assistance to perform the activity. If the patient is able to perform the activity by using accommodating equipment, such as a cane, walker, commode, etc., the patient is considered able to independently perform the activity without requiring assistance.

Requires Assistance is defined as:

- physical assistance (hands-on),
- stand-by assistance (within arm's reach),
- verbal assistance (must be instructed because of cognitive impairment),

without which the patient would be **INCAPABLE** of performing the task.

What is the predominant reason the patient is/was unable to independently perform ADL?

- Traumatic Brain Injury Other Traumatic Injury

(Please describe injury and give reason(s) it resulted in inability to perform activities of daily living.)



PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd)

What is the predominant reason the patient is/was unable to independently perform ADL?

Check the predominant reason the patient cannot independently perform ADL and describe the injury in the box provided.

Which ADL is the patient unable to perform?

Check each ADL the patient cannot perform; AND; Fill in the dates inability began and ended or indicate inability is ongoing.

Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)

Unable to bathe independently

Start date:

--	--	--	--	--	--

 End date:

--	--	--	--	--	--

OR Check here if inability is ongoing

Type of assistance required (check all that apply)

- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
 stand-by assistance (within arm's reach)

Patient is UNABLE to bathe independently if...

He/she requires assistance from another person to bathe (including sponge bath) more than one part of the body or get in or out of the tub or shower.

Describe assistance needed:

Unable to maintain continence independently

Start date:

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 End date:

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OR Check here if inability is ongoing

Type of assistance required (check all that apply)

- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
 stand-by assistance (within arm's reach)

Patient is UNABLE to maintain continence independently if...

He/she is partially or totally unable to control bowel and bladder function or requires assistance from another person to manage catheter or colostomy bag.

Describe assistance needed:

Unable to dress independently

Start date:

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 End date:

--	--	--	--	--	--

OR Check here if inability is ongoing

Type of assistance required (check all that apply)

- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
 stand-by assistance (within arm's reach)

Patient is UNABLE to dress independently if...

He/she **requires** assistance from another person to get and put on clothing, socks or shoes.

Describe assistance needed:

Unable to eat independently

Start date:

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 End date:

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OR Check here if inability is ongoing

Type of assistance required (check all that apply)

- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
 stand-by assistance (within arm's reach)

Patient is UNABLE to eat independently if...

He/she **requires** assistance from another person to:

- get food from plate to mouth OR,
 - take liquid nourishment from a straw or cup OR,
- he/she is fed intravenously or by a feeding tube

Describe assistance needed:



PART B - Medical Professional's Statement (cont'd) to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security Number

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3 Qualifying Losses Suffered by Patient (cont'd) **Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)**

Require Assistance is defined as:

- physical assistance (hands-on),
 - stand-by assistance (within arm's reach),
 - verbal assistance (must be instructed because of cognitive impairment),
- without which the patient would be INCAPABLE of performing the task.**

Unable to toilet independently

Start date:

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 End date:

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OR Check here if inability is ongoing

- Type of assistance required** (check all that apply)
- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
- stand-by assistance (within arm's reach)

Patient is UNABLE to toilet independently if...

He/she must use a bedpan or urinal to toilet OR, he/she **requires** assistance from another person with any of the following: going to and from the toilet, getting on and off the toilet, cleaning self after toileting, getting clothing off and on.

Describe assistance needed:

Unable to transfer independently

Start date:

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 End date:

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OR Check here if inability is ongoing

- Type of assistance required** (check all that apply)
- physical assistance (hands-on) verbal assistance (must be instructed because of cognitive impairment)
- stand-by assistance (within arm's reach)

Patient is UNABLE to transfer independently if...

He/she **requires** assistance from another person to move into or out of a bed or chair.

Describe assistance needed:

4 Other Information

To your knowledge, were any of the losses indicated in Part B due to:

- a. an intentionally self-inflicted injury or an attempt to inflict such injury,
- b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor,
- c. the medical or surgical treatment of an illness or disease,
- d. a physical or mental illness or disease (not including illness or disease caused by a pyogenic infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance).

If yes, please explain below:

5 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries. When a narrative description is required, please be complete and concise.



