

United States Army Student Detachment
HR In-Processing
2016
Version 02

SERVICE MEMBER INFORMATION

Name:

Report date:

Grad/Completion date:

Rank:

Program:

Component:

REQUIRED DOCUMENTS:

- PCS Orders and amendments (if applicable)
- (DA Form 31, Sep 1993) Request and Authority for leave (W/Control Number)
- (DD Form 93, Jan 2008) Record of Emergency Data
- (SGLV 8286, Feb 2015) Service Members' Group Life Insurance Election & Certificate
- (DA Form 7415, Jun 2009) Exceptional Family Member Program (EFMP) Querying Sheet
- United States Army Student Detachment Policies Memorandum of Understanding (signed and dated)
- Contact TRICARE to update medical coverage (see toll free numbers enclosed)
- (DA Form 705, May 2010) Army Physical Fitness Test Scorecard (Current)
- Update ADPAAS (<https://adpaas.army.mil>) ****Print screen to show it has been updated****
- (DA Form 3955, Jan 2015) Change of Address and Directory Card (Submit to HRC)

I UNDERSTAND THAT NO ACTION/UPDATE WILL BE MADE UNTIL ALL REQUIRED DOCUMENTS HAVE BEEN RECEIVED.

SM SIGNATURE:

DATE:

REMARKS:

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).
PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. For military personnel, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. For civilian personnel, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.
ROUTINE USES: None.
DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancé), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death. It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME (Last, First, Middle Initial)		2. SSN	
3a. SERVICE/CIVILIAN CATEGORY <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> DoD <input type="checkbox"/> CIVILIAN <input type="checkbox"/> CONTRACTOR			b. REPORTING UNIT CODE/DUTY STATION
4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
5. CHILDREN a. NAME (Last, First, Middle Initial)	b. RELATIONSHIP	c. DATE OF BIRTH (YYYYMMDD)	d. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER
6a. FATHER NAME (Last, First, Middle Initial)	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER		
7a. MOTHER NAME (Last, First, Middle Initial)	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER		
8a. DO NOT NOTIFY DUE TO ILL HEALTH	b. NOTIFY INSTEAD		
9a. DESIGNATED PERSON(S) (Military only)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)			

INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If a computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP Code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 14, "Continuations/Remarks", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 14" should be included in the item pertaining to the particular next of kin or when the space for a particular item is insufficient. If the address for the person in the Item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. Those items that are considered not applicable to civilians will be left blank.

ITEM 1. Enter full last name, first name, and middle initial.

ITEM 2. Enter social security number (SSN).

ITEM 3a. Service. **Military:** Mark X in appropriate block. **Civilian:** Mark two blocks as appropriate. Examples: an Army civilian would mark Army and either Civilian or Contractor; a DoD civilian, without affiliation to one of the Military Services, would mark DoD and then either Civilian or Contractor as appropriate.

ITEM 3b. Reporting Unit Code/Duty Station. See Service Directives.

ITEM 4a. Spouse Name. Enter last name (if different from Item 1), first name and middle initial on the line provided. If single, divorced, or widowed, mark appropriate block.

ITEM 4b. Address and Telephone Number. Enter the "actual" address and telephone number, not the mailing address. Include civilian title or military rank and service if applicable. If one of the blocks in 4a is marked, leave blank.

ITEM 5a-d. Children. Enter last name (only if different from Item 1) first name and middle initial, relationship, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Relationship examples: son, daughter, stepson or daughter, adopted son or daughter or ward. Date of birth example: 19950704. For children not living with the member's current spouse, include address and name and relationship of person with whom residing in item 5d.

ITEM 6a. Father Name. Last name, first name and middle initial.

ITEM 6b. Address and Telephone Number of Father. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural father is listed, indicate relationship.

ITEM 7a. Mother Name. Last name, first name and middle initial.

ITEM 7b. Address and Telephone Number of Mother. If unknown or deceased, so state. Include civilian title or military rank and service if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons Not to be Notified Due to Ill Health.

a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan." Otherwise, enter "None".

b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a. If "None" is entered in Item 8a, leave blank.

ITEM 9a. This item will be used to record the name of the person or persons, if any, other than the member's primary next of kin or immediate family, to whom information on the whereabouts and status of the member shall be provided if the member is placed in a missing status. Reference 10 USC, Section 655. **NOT APPLICABLE to civilians.**

ITEM 9b. Address and telephone number of Designated Person(s). **NOT APPLICABLE to civilians.**

ITEM 10. Contracting Agency and Telephone Number (**Contractors only**). **NOT APPLICABLE to military personnel.** Civilian contractors will provide the name of their contracting agency and its telephone number. Example: XYZ Electric, (703) 555-5689. The telephone number should be to the company or corporation's personnel or human resources office.

ITEM 11a. Beneficiary(ies) for Death Gratuity (**Military only**). Enter first name(s), middle initial, and last name(s) of the person(s) to receive death gratuity pay. A member may designate one or more persons to receive all or a portion of the death gratuity pay. The designation of a person to receive a portion of the amount shall indicate the percentage of the amount, to be specified only in 10 percent increments, that the person may receive. If the member does not wish to designate a beneficiary for the payment of death gratuity, enter "None," or if the full amount is not designated, the payment or balance will be paid as follows:

- (1) To the surviving spouse of the person, if any;
- (2) To any surviving children of the person and the descendants of any deceased children by representation;
- (3) To the surviving parents or the survivor of them;
- (4) To the duly appointed executor or administrator of the estate of the person;
- (5) If there are none of the above, to other next of kin of the person entitled under the laws of domicile of the person at the time of the person's death.

The member should make specific designations, as it expedites payment.

INSTRUCTIONS FOR PREPARING DD FORM 93

(Continued)

ITEM 11a. (Continued) Seek legal advice if naming a minor child as a beneficiary. If a member has a spouse but designates a person other than the spouse to receive all or a portion of the death gratuity pay, the Service concerned is required to provide notice of the designation to the spouse. **NOT APPLICABLE to civilians.**

Item 11b. Relationship. **NOT APPLICABLE to civilians.**

ITEM 11c. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 11d. Show the percentage to be paid to each person. Enter 10%, 20%, 30%, up to 100% as appropriate. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named. **NOT APPLICABLE to civilians.**

ITEM 12a. Beneficiary(ies) for Unpaid Pay/Allowance (Military only). Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "By Law." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2771) in the absence of a designation. Seek legal advice if naming a minor child as beneficiary. **NOT APPLICABLE to civilians.**

ITEM 12b. Enter beneficiary(ies) full mailing address and telephone number to include the ZIP Code. **NOT APPLICABLE to civilians.**

ITEM 12c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent. **NOT APPLICABLE to civilians.**

ITEM 13a. Enter the name and relationship of the Person Authorized to Direct Disposition (PADD) of your remains should you become a casualty. Only the following persons may be named as a PADD: surviving spouse, blood relative of legal age, or adoptive relatives of the decedent. If neither of these three can be found, a person standing in loco parentis may be named. **NOT APPLICABLE to civilians.**

ITEM 13b. Address and telephone number of PADD. **NOT APPLICABLE to civilians.**

ITEM 14. Continuations/Remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./son/ 19851220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed. This block offers the greatest amount of flexibility for the member to record other important information not otherwise requested but considered extremely useful in the casualty notification and assistance process. Besides continuing information from other blocks on this form, the member may desire to include additional information such as: NOK language barriers, location or existence of a Will, additional private insurance information, other family member contact numbers, etc. If additional space is required, attach a supplemental sheet of standard bond paper with the information.

ITEM 15. Signature of Service Member/Civilian. Check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade if applicable. May be electronically signed (see DoD Instruction 1300.18 for guidelines).

ITEM 16. Signature of Witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade as appropriate. A witness signature is not required for electronic versions of the DD Form 93 (see DoD Instruction 1300.18).

ITEM 17. Date the member or civilian signs the form. This item is an ink entry and must be completed on all copies.



Prudential

Office of Servicemembers'
Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

1. About You

Print Name (First, Middle, Last)

Rank, title or grade

Social Security Number

Duty Location

Branch of Service

Current Amount of SGLI

2. About Your Coverage (This form replaces all prior designations)

I am completing this form to: (Check all that apply)

- Name or update my SGLI beneficiary. You must complete sections 3 & 5.
- Increase or restore my SGLI coverage to \$ _____. You must complete sections 3, 4, & 5. (Increasing SGLI does not automatically increase FSGLI, if FSGLI was < \$100,000.)
- Reduce my SGLI coverage to \$ _____. You must complete sections 3 & 5.
- Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5 only.
" _____ "

Coverage is available in increments of \$50,000 up to a maximum of \$400,000.

3. About Your Beneficiaries (Please always complete this section unless you are declining coverage. If you do not specifically name beneficiaries, your insurance will be paid by law. Please read the information on page 3 before selecting your beneficiaries.)

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts. The sum of the shares must equal 100% or the full dollar amount of your insurance.) (Each share must be greater than \$0.00 or 0%)	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>	<input type="text"/>		
2.	<input type="text"/>	<input type="text"/>		
3.	<input type="text"/>	<input type="text"/>		
4.	<input type="text"/>	<input type="text"/>		
Secondary				
1.	<input type="text"/>	<input type="text"/>		
2.	<input type="text"/>	<input type="text"/>		
3.	<input type="text"/>	<input type="text"/>		
4.	<input type="text"/>	<input type="text"/>		

Have more beneficiaries? Check this box if 1.) you have additional beneficiaries and are completing the Supplemental SGLI Beneficiary Form, SGLV 8286S or, 2.) You are attaching additional documentation to complete your beneficiary designation noted above.

* If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The Bank of New York Mellon is the Administrator 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. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

4. About Your Health Complete this section *ONLY* if you are restoring or increasing coverage.

Your gender Female
 Male

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Have you had, been treated for, or had known indications of:

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. A heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A neurological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cancer or tumors? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever been diagnosed as having a disease of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Do you have any known physical impairments, deformities, or ill health not covered above? | <input type="checkbox"/> | <input type="checkbox"/> |

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below. Please attach additional documentation if necessary.

If you answered "yes" to any question above, a request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI). If you answered "no" to all the questions above, your request for increased coverage takes effect immediately.

5. Your Signature You must complete this section.

I have read the information on page 3 and instructions on page 4 and understand that:

- This form replaces any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) coverage at the same time, but the combined amount cannot be more than \$400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions on page 4).

Please take note:

If my spouse is...	and...	then...
also a member of the uniform services	we married on or after January 2, 2013	spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 8286A.
not a member of the uniformed services	I am married, or get married after completing this form, and have not declined SGLI,	spouse SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. Failure to do so will result in a debt for unpaid premiums. I can decline spouse coverage by completing SGLV 8286A.

- I am free to name anyone I want as my beneficiary. I understand if I am married and have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that my spouse may be notified that he/she (or my child) is not my designated beneficiary.

I certify that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits.

Service Member Signature

Social Security Number

Date (MM, DD, YYYY)

Address

Submit this form to your Unit Personnel Clerk.

For Branch of Service Use Only

Name of Personnel Clerk

Rank, title or grade

Contact telephone/email

Date

Address

For OSGLI Use Only

Representative

Approve

Disapprove

Date

Information for the Service Member

About your SGLI Coverage

Servicemembers' Group Life Insurance (SGLI) is granted under title 38, United States Code, and is subject to the provisions of that title and its amendments, and title 38 Code of Federal Regulations.

The following charts provide information you should review before naming a beneficiary or selecting a payment option.

Naming Beneficiaries who will receive the insurance

If you...	Then...
are married and decline coverage upon entry into service	your spouse will be notified that you declined coverage.
are married and designate any person other than your spouse or child for any amount of insurance	your spouse will be notified in writing, by the Branch of Service that he/she or your child is not the named beneficiary, unless: – your spouse has been previously notified, OR – your spouse is not designated as beneficiary for any amount of insurance prior to the new election.
are married and your spouse is designated as beneficiary and you decline coverage or elect less than maximum coverage, and that election reduces your coverage from the automatic maximum or from a previously elected amount of coverage	your spouse will be notified in writing of your election to decline or reduce coverage.
have any life event such as marriage, divorce, or children after completing this form	you should complete a new beneficiary form. Beneficiaries are not automatically changed by life events.
name more than one beneficiary	the sum of the shares must equal 100% or the full dollar amount of your insurance.
want to name more than four primary or secondary beneficiaries	you must complete the SGLI Supplemental Beneficiary Form, SGLV 8286S or attach additional documentation to complete your beneficiary designation.
name minors as beneficiaries	<ul style="list-style-type: none"> ■ OSGLI will pay the insurance benefit to the court-appointed guardian of the minor's estate if the beneficiary is a minor at time of claim; or ■ you can establish a trust for the benefit of the minor and name the trustee of the trust as beneficiary. ■ naming a trust as a beneficiary on this form does NOT create a trust.
name more than one primary beneficiary and one or more of them predeceases you	OSGLI will pay the shares equally among the remaining primary beneficiaries.
want to name a Trust as a beneficiary	you must create a trust. Please consult with a military attorney, professional financial planner, or estate planner to help you create Trust documents. (Please note: Do not send Trust documents to OSGLI until the time of claim).
have no surviving primary beneficiaries	OSGLI will pay the insurance benefit to the secondary beneficiaries, if any.
do not name a beneficiary or there are no surviving primary or secondary beneficiaries OR indicate that payment should be made by law	OSGLI will pay the insurance benefit in the following order: 1. Widow or widower 2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child) 3. Parent(s) in equal shares or all to surviving parent 4. A duly appointed executor or administrator of your estate 5. Other next of kin

Payment Options

If you want the beneficiary to...	Then...
receive the insurance proceeds in one lump sum	write the phrase "lump sum" under Payment Options. If you elect a lump sum payment, your beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account [®] , by check, or Electronic Funds Transfer (EFT). * Alliance Account is not available for payments less than \$5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.
receive the insurance proceeds in 36 equal monthly payments	<ul style="list-style-type: none"> ■ write "36" under the Payment Option. ■ your beneficiary cannot change this payment option.
have a choice	write the phrase "lump sum" under Payment Option or leave blank.

Instructions for Personnel Clerk and the Service Member

1. A representative of the Uniformed Services must complete the "For Branch of Service Official Use Only" section to indicate receipt of the form from the member after reviewing the following table:

If the service member...	The Personnel Clerk should inform the service member...	Then the Personnel Clerk should...
has just entered the service	he or she is automatically insured for \$400,000 SGLI, unless the service member declines or reduces coverage.	have the service member designate beneficiaries by completing SGLV 8286.
is increasing or restoring SGLI	he or she must complete Section 4, <i>About Your Health</i> .	<ul style="list-style-type: none"> ▪ approve form if the responses to questions 4a through 4g are "No" and forward the form to payroll to change SGLI premium deductions. ▪ send form to OSGLI if any answer to questions 4a through 4g are "Yes." Only inform payroll when approved by OSGLI.
Reduces, declines, or cancels SGLI	<ul style="list-style-type: none"> ▪ an application with health questions is required to increase, elect, or restore coverage at a later date. ▪ of the following: <ul style="list-style-type: none"> – the purpose and role of life insurance in financial planning. – the difference between term life insurance and whole life insurance. – the availability of commercial life insurance. – the relationship between SGLI and VGLI. – declining or canceling SGLI will also cancel Family SGLI—both spouse and dependent child coverage—and Traumatic Injury Protection (TSGLI). 	<ul style="list-style-type: none"> ▪ forward the form to payroll to change SGLI premium deductions. ▪ if canceling SGLI, have the service member complete SGLV 8286A to end payment of Family SGLI premiums. No form is required to end TSGLI premium deductions. ▪ if the member is married and reduces, declines, or cancels SGLI, inform the member that his/her spouse may be notified in writing, by the Branch of Service, of the member's election based on Title 38, USC 1967 (f).
gets married to another member of the uniformed services on or after January 2, 2013	spouse SGLI coverage is not automatic and the member may apply for spouse SGLI coverage by completing SGLV 8286A.	if member wants spouse SGLI coverage, provide the member with SGLV 8286A, Spouse Coverage Election and Certificate, and follow the instructions therein.
is married or gets married after completing this form and is not married to another member of the uniformed services	<ul style="list-style-type: none"> ▪ spouse SGLI automatically covers spouse. ▪ he or she must register their spouse in DEERS for payroll to deduct premiums. ▪ If the member wants to decline coverage or take a lesser amount of spouse coverage, the member must complete SGLV 8286A. 	if applicable, forward the form to payroll to begin premium deductions for the spouse coverage.
has questions about this form	the advice of a military attorney is available at no expense.	direct them to the appropriate resource.
wants to designate more beneficiaries than the form allows	he or she must complete the Supplemental SGLI Beneficiary Form SGLV 8286S or attach additional documentation to complete your beneficiary designation.	attach the Supplemental Beneficiary Form to the SGLV 8286 or attach additional documentation to complete your beneficiary designation.
designates any person other than his/her spouse or child for any amount of insurance	<ul style="list-style-type: none"> ▪ while the member is free to designate anyone he or she chooses as beneficiary, the member must certify that he or she is designating someone other than a spouse or child and the person named will receive the benefit. ▪ if the member is married, the member's spouse will be notified in writing by the Branch of Service, that he/she or the member's child is not the named beneficiary, unless: <ul style="list-style-type: none"> – the spouse has been previously notified, OR – the spouse is not designated as beneficiary for any amount of insurance prior to the new election. 	have the member sign SGLV 8286 to certify that he/she understands that: <ul style="list-style-type: none"> ▪ he/she is free to name anyone as beneficiary. ▪ if he/she designated someone other than his/her spouse or child as beneficiary, the person the member has named is the person he/she intends to receive the insurance proceeds. ▪ if married, the spouse will be notified that he/she (or any child) is not the designated beneficiary.

2. After the form is completed, Personnel Clerk should:

- File a copy in the member's official personnel file
- Provide a copy to the service member
- Provide a copy of the form to the payroll office for the member's unit
- Submit the form to OSGLI ONLY if the member is increasing or restoring SGLI coverage and answered "Yes" to one or more of the health questions

OSGLI

PO Box 41618

Philadelphia, PA 19176-9913

If a member is making a Beneficiary change only, the form DOES NOT have to be forwarded to OSGLI.

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUERYING SHEET

For use of this form, see AR 608-75; the proponent agency is ACSIM.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC Section 301, Departmental Regulations; 10 USC 1071-1085; 10 USC Section 3013, Secretary of the Army; and Army Regulation 608-75, EFMP.

PRINCIPAL PURPOSE: To identify soldiers that have family members for enrollment in the EFMP.

ROUTINE USES: To federal, state, and local medical agencies in order to provide an exceptional family member with medical treatment when the Department of the Army does not have a suitable treatment facility.

DISCLOSURE: Disclosure of the requested information is mandatory. Failure to provide the information may result in disciplinary and/or administrative action. Additionally, failure to provide the information may result in an EFM not receiving necessary medical care.

1. NAME OF SOLDIER	2. RANK
3. UNIT	
4a. HOME ADDRESS	b. HOME PHONE NUMBER
5a. DUTY ADDRESS	b. DUTY PHONE NUMBER
	c. FAX NUMBER
d. EMAIL ADDRESS	

6. Do you have a family member (*child or adult*) with a physical, emotional, developmental, or intellectual disorder that requires special treatment, therapy, education, training, counseling, equipment, assistance or medical care above the level of a general practitioner? YES NO

7. If the answer to the above question is yes, is the family member enrolled in EFMP? YES NO

8. The EFMP works with the other military and civilian agencies to provide comprehensive, coordinated community support, educational, housing, personnel, and medical services to families with special needs. Enrollment in EFMP is mandatory and benefits the family by considering medical and special education needs in the military personnel assignment process. Medical needs are considered in the worldwide assignment process whereas special education needs are only considered in overseas assignments.

9. The above information is true and correct to the best of my knowledge.

a. SIGNATURE OF SOLDIER	b. DATE SIGNED (YYYYMMDD)
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DEPARTMENT OF THE ARMY
UNITED STATES ARMY STUDENT DETACHMENT
5450 STROM THURMOND BOULEVARD ROOM 244
FORT JACKSON SOUTH CAROLINA 29207

ATZJ-DBI-SD

MEMORANDUM OF UNDERSTANDING

SUBJECT: United States Army Student Detachment (USASD) Policies

1. I have read and understand the USASD policy memorandums available under the USASD webpage at <http://usasd.armylive.dodlive.mil/>.
2. I understand that these memorandums are guidelines that I must follow while assigned to the USASD, along with guidelines established by the U.S. Army Human Resources Command (HRC) at <https://www.hrc.army.mil/Officer/Officer%20Personnel%20Management%20Directorate>, the Foreign Area Officer Branch and the Advanced Education Programs Branch at <https://www.hrc.army.mil/Officer/Officer%20Advanced%20Education%20Programs> for Advance Civil Schooling (ACS), Broadening Opportunity Programs (BOP) (Fellowships; Scholarships; Degree Completion Program (DCP); Cooperative Degree Program (CDP)) and Training with Industry (TWI).
3. I understand it is my responsibility to regularly view the USASD website to stay abreast of any changes or requirements that may occur during my tenure as a Student.
4. I understand that I should check my Enterprise and Microsoft Outlook email account(s) at least 3 times a week.
5. I understand it is mandatory to participate in Personnel Asset Inventory (PAI) twice a year and submit required documents as posted in the USASD website under the PAI tab. PAI submission dates are from 01 April through 15 May and 01 October through 15 November.
6. My signature below confirms that I have read and understand the USASD policies and guidelines established by HRC.

_____ (Print Name)

_____ (Rank/Branch)

_____ (Signature)

_____ (Date)



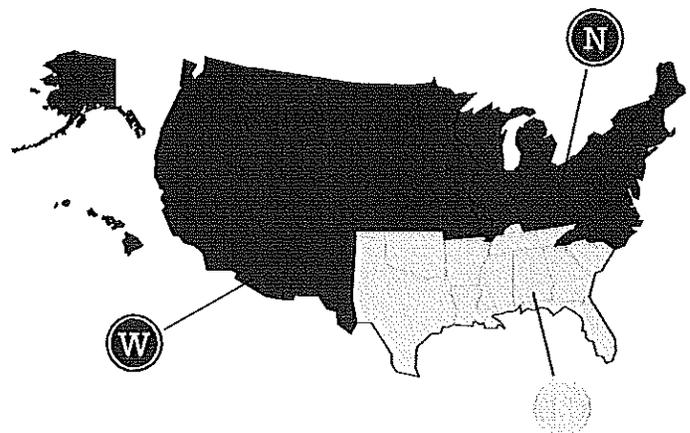
TRICARE® Resources for Service

This overview provides a snapshot of TRICARE service and support resources offered through a variety of convenient Internet options and toll-free call centers.

Visit the "I want to ..." section at www.tricare.mil to:

- Enroll in or Purchase a Plan
- File or Check a Claim
- View Referrals and Prior Authorizations
- Find a Doctor
- Look Up Costs
- Change Your Primary Care Manager
- See What's Covered
- Compare Plans
- Manage Prescriptions

... and more



TRICARE Regional Contractors

Regional contractors work with the Department of Defense to administer the TRICARE medical benefit.

STATESIDE



North Region

Health Net Federal Services, LLC
1-877-TRICARE (1-877-874-2273)
www.hnfs.com



South Region

Humana Military, a division of
Humana Government Business
1-800-444-5445
HumanaMilitary.com



West Region

UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

OVERSEAS

TRICARE Overseas Program (TOP)

International SOS Government Services, Inc.
www.tricare-overseas.com



TOP Regional Call Centers

Eurasia-Africa

+44-20-8762-8384 (overseas)
1-877-678-1207 (stateside)

Latin America and Canada

+1-215-942-8393 (overseas)
1-877-451-8659 (stateside)

Pacific (Singapore)

+65-6339-2676 (overseas)
1-877-678-1208 (stateside)

Pacific (Sydney)

+61-2-9273-2710 (overseas)
1-877-678-1209 (stateside)

SIGN UP FOR eCORRESPONDENCE

Visit <http://milconnect.dmdc.mil> to provide your e-mail address and receive eCorrespondence for important information about your TRICARE benefit.

KEEP YOUR DEERS INFORMATION UP TO DATE!

It is important to keep your information in the Defense Enrollment Eligibility Reporting System (DEERS) up to date: www.tricare.mil/deers

You have several convenient options for updating DEERS:

- milConnect: <http://milconnect.dmdc.mil>
- 1-800-538-9552 or 1-866-363-2883 (TDD/TTY)
- 1-831-655-8317 (fax)

Find a local identification card-issuing facility:
www.dmdc.mil/rs1

Sign up for a DS Logon in order to log in to milConnect:
<https://myaccess.dmdc.osd.mil>

TRICARE PROGRAM COSTS

Health care costs vary depending on your TRICARE program option. Get the latest TRICARE cost information including dental and pharmacy costs.

www.tricare.mil/costs

TRICARE COVERED SERVICES

Get details about TRICARE coverage, limitations, and exclusions.

www.tricare.mil/coveredservices

GETTING CARE

Find a doctor: www.tricare.mil/findaprovider

Military hospital and clinic appointments online:
www.tricareonline.com

Military hospital and clinic locator: www.tricare.mil/mtf

TRICARE Programs and Resources

TRICARE Pharmacy Program www.tricare.mil/pharmacy
Express Scripts, Inc. www.express-scripts.com/TRICARE
1-877-363-1303

TRICARE Active Duty Dental Program www.tricare.mil/addp
www.addp-ucci.com
1-866-984-2337
United Concordia Companies, Inc.

TRICARE Dental Program www.tricare.mil/tdp
MetLife www.metlife.com/tricare
1-855-638-8371 (stateside)
+1-855-638-8372 (overseas)

TRICARE Retiree Dental Program www.tricare.mil/trdp
www.trdp.org
Delta Dental of California 1-888-838-8737

TRICARE For Life www.tricare.mil/tfl
Wisconsin Physicians Service www.TRICARE4u.com
1-866-773-0404

Continued Health Care Benefit Program www.tricare.mil/chcbp
Humana Military HumanaMilitary.com
1-800-444-5445

US Family Health Plan www.tricare.mil/usfhp
www.usfhp.com
1-800-748-7347

Tobacco-Cessation Resources

North Region Tobacco Quitline: 1-866-459-8766
South Region Tobacco Quitline: 1-877-414-9949
West Region Tobacco Quitline: 1-888-713-4597

TRICARE Web site: www.tricare.mil/tobaccocessation
UCanQuit2 Web site: www.ucanquit2.org

New to TRICARE

Learn more about TRICARE—watch an overview video and take the free public TRICARE Fundamentals course online:
www.tricare.mil/new

ADDITIONAL RESOURCES

TRICARE Contacts: www.tricare.mil/contactus

TRICARE SMART Site (view/download TRICARE materials):
www.tricare.mil/smart

Claims: www.tricare.mil/claims

Enrollment: www.tricare.mil/enroll

Forms: www.tricare.mil/forms

Frequently Asked Questions: www.tricare.mil/faqs

Mental Health Care: www.tricare.mil/mentalhealth

Defense Health Agency—Great Lakes: 1-888-647-6676

Customer Service Community Directory:
www.tricare.mil/bcacdcao

TRICARE Nurse Advice Line: 1-800-TRICARE (1-800-874-2273)

National Suicide Prevention Lifeline: 1-800-273-8255, Press 1

Military OneSource: www.militaryonesource.mil

Report Fraud and Abuse: www.health.mil/fraud

1. NAME (Last, First, MI):		2. GRADE:	3. PURGE DATA (P.O. Use Only):
4. NEW ORGANIZATION (Complete Designation):		5. DoD ID NUMBER:	6. BOX NUMBER:
<small>DATA REQUIRED BY THE PRIVACY ACT OF 1974. AUTHORITY: Title 39 USC and DoD/Postal Service Agreement, 2 FEB 80. PRINCIPAL PURPOSE: To route and forward (Directory) mail. ROUTINE USES: Used by Army military and civilian personnel in mail functions and address inquiries. Dates are inspected by commanders, postal officers, and military and civilian inspectors. DISCLOSURE: Voluntary. However, failure to provide the requested information could result in delay/inability to forward mail.</small>			
7. OLD MAILING ADDRESS (Include BOX No., if any, and ZIP Code):		8. NEW MAILING ADDRESS (Including ZIP Code):	
9. DATE DEPARTED OLD ORG:		10. DATE DUE NEW ORG:	
11. EMAIL ADDRESS:		12. LIST EACH AUTHORIZED FAMILY MEMBER:	
13. IS THIS MOVE TEMPORARY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
14. IF YES, FORWARDING ENDS:			
16. CHANGE OF ADDRESS FOR: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY			
16. SIGNATURE:		17. DATE:	18. PHONE NUMBER:

DA FORM 3955, JAN 2015

PREVIOUS EDITIONS ARE OBSOLETE.

APD LG vt.00ES

CHANGE OF ADDRESS AND DIRECTORY CARD
 For use of this see AR 600-8-3, the proponent agency is DCS, G-1.

You are required to forward a DA Form 3955, Change of Address Card, containing your new home address, your phone number, and current home and duty electronic mail address to your HRC – Knox assignment manager within 30 days of arrival at your new duty station or upon change of residence.

HRC Branch Manager Link :

<https://www.hrc.army.mil/Officer/Officer%20Personnel%20Management%20Directorate>

UIC and Student's Programs
Use This Page To Complete In-Processing Form

UIC	Location	UIC	Location
W30U1A	Incoming Personnel	W30U2Y	Tennessee
W30U1B	FAO	W30U2Z	Texas
W30U1C	OCONUS, SON	W30U3A	Utah
W30U1D	Wounded Warrior	W30U3B	Vermont
W30U1E	Alabama	W30U3C	Virginia
W30U1F	Alaska	W30U3D	Washington
W30U1G	Arizona	W30U3E	West Virginia
W30U1H	Arkansas	W30U3F	Wisconsin
W30U1J	California	W30U3G	Wyoming
W30U1K	Colorado		
W30U1L	Connecticut	Programs	
W30U1M	Delaware	Advanced Civil Schooling (ACS)	
W30U1N	Washington D.C.	Cooperative Degree Program (CDP)	
W30U1P	Florida	Degree Completion Program (DCP)	
W30U1Q	Georgia	Expanded Graduate School Program (EGSP)	
W30U1R	Hawaii	Foreign Area Officer (FAO)	
W30U1S	Idaho	Funded Legal Education Program (FLEP)	
W30U1T	Illinois	Green To Gold (G2G)	
W30U1U	Indiana	Scholarship/Fellowship/Internships	
W30U1V	Iowa	School of Other Nations (SON)	
W30U1W	Kansas	Senior Service College Fellowships	
W30U1X	Kentucky	Training with Industry (TWI)	
W30U1Y	Louisiana		
W30U1Z	Maine		
W30U2A	Maryland		
W30U2B	Massachusetts		
W30U2C	Michigan		
W30U2D	Minnesota		
W30U2E	Mississippi		
W30U2F	Missouri		
W30U2G	Montana		
W30U2H	Nebraska		
W30U2J	Nevada		
W30U2K	New Hampshire		
W30U2L	New Jersey		
W30U2M	New Mexico		
W30U2N	New York		
W30U2P	North Carolina		
W30U2Q	North Dakota		
W30U2R	Ohio		
W30U2S	Oklahoma		
W30U2T	Oregon		
W30U2U	Pennsylvania		
W30U2V	Rhode Island		
W30U2W	South Carolina		
W30U2X	South Dakota		