

PHYSICIAN CERTIFICATE FOR CHILD ANNUITANT

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The public reporting burden for this collection of information is estimated to average 1 hour 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, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. 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.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO: Defense Finance and Accounting Service, U.S. Military Annuitant Pay, 8899 E 56th Street, Indianapolis IN 46249-1300.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C., "Armed Forces," Section 1435, "Eligible Beneficiaries," Section 1447, "Definitions," DoDFMR, Vol 7B, Ch 46, "Survivor Benefit Plan - Annuity Amount and Offsets," and Executive Order 9397, as amended, "Numbering System for Federal Accounts Relating to Individual Persons."

PRINCIPAL PURPOSE(S): The Survivor Benefit Plan (SBP) and the Retired Serviceman's Family Protection Plan (RSFPP), provide for the coverage of children who are unmarried and incapable of self-support because of mental and/or physical incapacitation. If the incapacitation is temporary, recertification of this incapacitation is required every 2 years when the child annuitant is age 18 or over.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records, or information contained therein, may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to Internal Revenue Service for tax administration; Department of Veterans Affairs for pay entitlements; Social Security Administration for pay entitlements; American Red Cross for locator service; military aid societies for family assistance; Office of Personnel Management for pay entitlements and DoD Blanket Routine Uses at: <http://dpclid.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses/>. SORN T7347b, Defense Retiree and Annuitant Pay System at: <http://dpclid.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570196/t7347b/>. PIA, Defense Retiree and Annuitant Pay System at: [https://www.dfas.mil/dam/jcr:5cf8a068-89c7-47eb-b844-1e2020ed5f73/Defense%20Retiree%20and%20Annuitant%20Pay%20System%20\(DRAS\)%202016.pdf](https://www.dfas.mil/dam/jcr:5cf8a068-89c7-47eb-b844-1e2020ed5f73/Defense%20Retiree%20and%20Annuitant%20Pay%20System%20(DRAS)%202016.pdf).

DISCLOSURE: Voluntary; however, if DFAS does not receive this information, the annuity payments will stop.

NOTE: Penalty for presenting false claims or making false statements in connection with claims is a fine of not more than \$10,000 or imprisonment for not more than 5 years, or both (18 U.S.C. 1001).

1. DECEASED MEMBER SSN	2. ANNUITANT'S NAME <i>(Last, First, Middle Initial)</i>	3. DATE OF BIRTH (YYYYMMDD)	4. ANNUITANT'S SSN
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5. BRIEF DESCRIPTION OF MEDICAL/PSYCHIATRIC DIAGNOSIS	6. DATE CONDITION BEGAN (YYYYMMDD)
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7. PHYSICIAN'S STATEMENT

a. I have attended the patient for _____ years _____ months

b. I last examined the patient on: _____

c. In my opinion the patient is *(X one or both)*

(1) Incapable of self-support for the period _____

(2) Incapable of handling his/her own financial affairs for the period _____

d. In my opinion the incapacity is *(X one)* permanent temporary If temporary, expected recovery date (YYYYMMDD)

e. I am a licensed

physician or practitioner authorized to practice medicine in the state of _____

psychiatrist authorized to practice medicine in the state of _____

8. I HEREBY CERTIFY THAT THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

a. PRINT PHYSICIAN'S NAME <i>(Last, First, Middle Initial)</i>	b. ADDRESS <i>(Include ZIP Code)</i>
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c. SIGNATURE	d. DATE (YYYYMMDD)
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