

# RECEIPTS CHECK-OFF SHEET

**PURPOSE:** The RECEIPTS Check-Off Sheet is to be utilized by Command Pass Coordinators to ensure RECEIPTS Packages are submitted accurately and completely. When complete, send the RECEIPTS Package via TOPS for processing.

NAME (LAST, FIRST MI):	RANK/RATE:	COMMAND:
CPC'S INITIALS	CPC NAME:	CPC PHONE NUMBER:
	<b>PERMANENT CHANGE OF STATION ORDERS AND MODIFICATIONS (IF ANY):</b> <ul style="list-style-type: none"> <li>▪ Orders and modifications must be complete, legible, and properly endorsed.</li> </ul>	
	<b>ENSURE THE FOLLOWING IS ATTACHED (CHECK OFF):</b> <ul style="list-style-type: none"> <li>▪ <b>DD 1351-1/DD1351-2C:</b> Ensure the travel claim is completely filled out. Travel itinerary MUST commence from the last Permanent Duty Station (last PDS) indicated on the orders, and shall end upon the arrival at the new PDS.</li> <li>▪ <b>OFFICIAL FLIGHT ITINERARY:</b> For member and ALL dependents.</li> <li>▪ <b>PORT CALL MESSAGE / TRAVEL ADVICE (IF ANY)</b></li> </ul>	
	<b>RECORD OF EMERGENCY DATA (PAGE 2) UPDATE:</b> <ul style="list-style-type: none"> <li>▪ <b>PLEASE READ:</b> Page 2 updates shall have pen and ink changes. If the member is in a TLA status, indicate the TLA address. PNOK/SNOK/PADD shall be updated with relationship, current address and phone numbers. Officer's page 2 must indicate Home of Record.</li> <li>▪ <b>INVALID UPDATES:</b> Page 2 will not be updated to only reflect the new PDS, Rate/Rank.</li> <li>▪ <b>VALID UPDATES:</b> consist of the following:               <ul style="list-style-type: none"> <li>✓ DEPENDENT ADDRESS CHANGE</li> <li>✓ CHANGE BENEFICIARIES</li> <li>✓ ADD/REMOVE DEPENDENTS</li> <li>✓ UPDATE PNOK/SNOK/PADD</li> <li>✓ UPDATES TO SGLI HAVE BEEN MADE</li> </ul> </li> </ul>	
	<b>SERVICE MEMBERS GROUP LIFE INSURANCE / FAMILY SGLI UPDATE:</b> <ul style="list-style-type: none"> <li>▪ SGLI/FSGLI (IF APPLICABLE; SEE FORM FOR VALID REASONS TO FILL OUT NEW SGLI FORM.)</li> </ul>	
	<b>BAH PAGE 13 (STATEMENT OF UNDERSTANDING FOR BAH ENTITLEMENT):</b> <b>***ONLY REQUIRED IF THE MEMBER IS REQUESTING BAH SINGLE***</b> <b>Please not the following:</b> <ol style="list-style-type: none"> <li>1. Address of permanent residence is required on P.13 before Single BAH will be started.</li> <li>2. For E6 and above on sea duty/E7 and above on shore duty, P.13 with address is the only requirement to start Single BAH.</li> <li>3. For all E5 and below or E6 on shore duty, the following is required to start Single BAH: P.13, Command/JBPHH BEQ Approval.</li> </ol>	
	<b>TLA (IF APPLICABLE):</b> Submit in a separate TOPS transaction.	
	<b>MEMORANDUM FOR ADDITIONAL SPECIAL PAYS (SDAP, DIVE PAY, DEMO, ETC):</b>	
	<b>NOTES:</b>	

**CPC CERTIFICATION:**

"I certify that all the required documentation has been completed and is attached. I understand that an incomplete package may be returned for correction, which will cause delays in the check-in processing, and possible overpayment of pay, allowances, and travel entitlements."

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CPC Signature and Date

**PSD PEARL HARBOR  
MEMBER'S PERSONAL INFORMATION SHEET**

TOPS#:		TOPS INITIAL DATE:	
RANK/RATE;	MEMBER'S NAME:		SSN:
PHONE #:		EMAIL:	
MEMBER'S RESIDENCE ADDRESS:			
COMMAND NAME:			
COMMAND UIC:		REPORT DATE:	
CPC NAME:	PHONE #:	EMAIL:	
PROCESSING DATE/TIME:		PROCESSING CLERK:	

**REMARKS SECTION:  
(SPECIAL CIRCUMSTANCES NEEDED FOR ANNOTATION)**


**PRIVACY ACT STATEMENT**

AUTHORITY: 5 U.S.C. SECTION 5701, 37 U.S.C. SECTIONS 404-427, 5 U.S.C. SECTION 301, DODFMR 7000.14-R, VOL. 7 PART A, AND E.O. 9397.  
 PRINCIPAL PURPOSE(S): THIS RECORD IS USED FOR REVIEWING, APPROVING, AND ACCOUNTING FOR GENERAL PURPOSE IN-HOUSE PROCESSING.

ROUTINE USE(S): DISCLOSURES ARE PERMITTED UNDER 5 U.S.C. 552A(B), PRIVACY ACT OF 1974, AS AMENDED. IN ADDITION, INFORMATION MAY BE DISCLOSED TO ANY COMPETENT LAWFUL AUTHORITY WHEN REQUIRED BY LAW.

DISCLOSURE: VOLUNTARY; HOWEVER, FAILURE TO FURNISH THE INFORMATION REQUESTED MAY RESULT IN NON-PROCESSING OF SERVICE MEMBER'S PAYS.

<b>TRAVEL VOUCHER OR SUBVOUCHER</b>				<b>Read Privacy Act Statement, Penalty Statement, and Instructions on back before completing form. Use typewriter, ink, or ball point pen. PRESS HARD. DO NOT use pencil. If more space is needed, continue in remarks.</b>					
<b>1. PAYMENT</b>		<b>SPLIT DISBURSEMENT:</b> The Paying Office will pay directly to the Government Travel Charge Card (GTCC) contractor the portion of your reimbursement representing travel charges for transportation, lodging, and rental car if you are a civilian employee, unless you elect a different amount. Military personnel are required to designate a payment that equals the total of their outstanding government travel card balance to the GTCC contractor. <b>NOTE: A split disbursement is only necessary when a GTCC is used while on official travel for the Government.</b>							
<input type="checkbox"/> Electronic Fund Transfer (EFT)		<input type="checkbox"/> Payment by Check				Pay the following amount of this reimbursement directly to the Government Travel Charge Card contractor: \$ _____			
<b>2. NAME</b> (Last, First, Middle Initial) (Print or type)			<b>3. GRADE</b>		<b>4. SSN</b>		<b>5. TYPE OF PAYMENT</b> (X as applicable)		
<b>6. ADDRESS.</b> a. NUMBER AND STREET			b. CITY		c. STATE		d. ZIP CODE		
e. E-MAIL ADDRESS			<input type="checkbox"/> TDY		<input type="checkbox"/> Member/Employee		<input type="checkbox"/> PCS		
			<input type="checkbox"/> Dependent(s)		<input type="checkbox"/> Other		<input type="checkbox"/> DLA		
<b>7. DAYTIME TELEPHONE NUMBER &amp; AREA CODE</b>				<b>8. TRAVEL ORDER/AUTHORIZATION NUMBER</b>		<b>9. PREVIOUS GOVERNMENT PAYMENTS/ ADVANCES</b>		<b>10. FOR D.O. USE ONLY</b>	
<b>11. ORGANIZATION AND STATION</b>								a. D.O. VOUCHER NUMBER	
<b>12. DEPENDENT(S)</b> (X and complete as applicable)				<input type="checkbox"/> ACCOMPANIED		<input type="checkbox"/> UNACCOMPANIED		b. SUBVOUCHER NUMBER	
a. NAME (Last, First, Middle Initial)		b. RELATIONSHIP		c. DATE OF BIRTH OR MARRIAGE		<b>13. DEPENDENTS' ADDRESS ON RECEIPT OF ORDERS</b> (Include Zip Code)		c. PAID BY	
						<b>14. HAVE HOUSEHOLD GOODS BEEN SHIPPED?</b> (X one)		d. COMPUTATIONS	
				<input type="checkbox"/> YES		<input type="checkbox"/> NO (Explain in Remarks)			
<b>15. ITINERARY</b>				c. MEANS/ MODE OF TRAVEL	d. REASON FOR STOP	e. LODGING COST	f. POC MILES		
a. DATE	b. PLACE (Home, Office, Base, Activity, City and State; City and Country, etc.)								
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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 (See Note)	- T	Automobile	- A
Government Transportation	- G	Motorcycle	- M
Commercial Transportation		Bus	- B
(Own expense)	- 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.

SHIP OR STATION

STATEMENT OF UNDERSTANDING FOR BAH ENTITLEMENT

BAH DEPENDENTS AT PDS LOCATION:

\_\_\_\_\_ : I ( ) hereby understand that my eligibility of BAH with dependents is based upon the dependents listed on my NAVPERS 1070/602. I further understand that if there is a change in dependency status (marriage, divorce, death or birth), dependent's address and/or assignment to government quarters that I must immediately notify the Personnel Officer and update my NAVPERS 1070/602.

I also certify that the address shown below is the primary residence of my dependents.

BAH DEPENDENTS AT DEPENDENTS LOCATION:

\_\_\_\_\_ : I ( ) hereby understand that my eligibility of BAH at dependents location requires Commanding Officer's approval (Afloat commands only). The request chit with the CO's endorsement must be on file at PSD. I understand I must provide original supporting documents to validate entitlement for BAH Dependents Location. I further understand that if there is a change in dependent's address or dependency status (marriage, divorce, death or birth) that I must immediately notify the Personnel Officer and update my NAVPERS 1070/602.

I also certify that the address shown below is the primary residence of my dependents.

**OUTCONUS LOCATIONS:** I certify that I have read and fully understood the Early Return of Dependents (ERD) policy contained in JFTR Volume 1 paragraph U10207.

BAH SINGLE:

\_\_\_\_\_ : I ( ) hereby reaffirm my request for Single BAH in lieu of assignment to government quarters and understand that I must have a commercial residence in the vicinity of the homeport. I understand that my eligibility requires the Commanding Officer and CBH Director's final approval, except E6 and above (afloat) and E7 and above (SHORE). I further certify that I must maintain a residence to receive continuous entitlement to BAH Single. I also understand that it is my responsibility to report any change to my living arrangements and if applicable the status of my military spouse to the Personnel Support Detachment.

I also certify that the address shown below is also the same address listed on the Command Recall Bill.

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any member who submits a claim for BAH which contain a false statement maybe subject to a disciplinary action for violation of the UCMJ and/or administrative action, including processing for administrative separation. In addition, fraudulent acceptance of benefits may cause a civilian recipient to be subject to criminal prosecution. The law provides for severe penalties of imprisonment and a fine. For military personnel, it can include dishonorable discharge, total forfeitures and confinement. You are required to ensure your Page 2 is accurate and that changes in dependent status (marriage, birth, divorce, separation or death) or location, are immediately reported to the chain of command and your servicing Personnel Support Detachment (Ship or PSD Afloat).

MEMBER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME (Last, First Middle)	SSN	USN	
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### 1. About You

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Duty Location	Branch of Service	Current Amount of SGLI

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.
- Reduce my SGLI coverage to \$ \_\_\_\_\_. You must complete sections 3 & 5.
- Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." You must complete section 5.  
" \_\_\_\_\_ "

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

### 3. About Your Beneficiaries Complete this section unless you are declining coverage

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (% or \$ amounts)	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			
<b>Secondary</b>				
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

**Have more beneficiaries?** Check the box and complete Supplemental SGLI Beneficiary Form, SGLV 8286S.

**If you do not name beneficiaries above, your insurance will be paid by law (see page 3).**

\*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.

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 UMB 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., UMB Bank, N.A., and First Data Payment Services are not Prudential Financial companies.

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

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender  Female  
 Male

**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"/> |

Any request to increase coverage does not take effect until approved by OSGLI.

**Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.**

**5. Your Signature** You must complete this section.

**I have read the instructions and understand that:**

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and 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 for details).
- If I am married or get married after completing this form and have not declined SGLI, Family 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 register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

Service Member Signature

Social Security Number

Date (MM, DD, YYYY)

Address

For Branch of Service Use Only	For OSGLI Use Only
Name of Personnel Clerk	Representative
Rank, title or grade	Approve <input type="checkbox"/>
Contact telephone/email	Disapprove <input type="checkbox"/>
Date	Date
Address	

## 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 name someone other than your spouse or child as your beneficiary	The Branch of Service will notify your spouse that he or she is not the named beneficiary.
are married and reduce or decline your coverage	The Branch of Service will notify your spouse that you reduced or declined 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.
name minors as beneficiaries	<ul style="list-style-type: none"> <li>■ SGLI will pay the insurance benefit to the court-appointed guardian of the children's estate, if the beneficiary is a minor at time of claim.</li> <li>■ You can establish a trust for the benefit of the children and name the trust as beneficiary. A trust names a trustee of your choice to be legally responsible for administering the insurance proceeds for the children.</li> <li>■ Naming a trust as a beneficiary on this form does NOT create a trust.</li> </ul>
name more than one primary beneficiary and one or more of them predeceases you	SGLI 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: Trust documents are not needed until a claim is submitted.)
have no surviving primary beneficiaries	SGLI will divide the insurance benefit among the secondary beneficiaries.
do not name a beneficiary or there are no surviving primary or secondary beneficiaries OR indicate that payment should be made by law	<p>SGLI will pay the insurance benefit in the following order:</p> <ol style="list-style-type: none"> <li>1. Widow or widower</li> <li>2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child)</li> <li>3. Parent(s) in equal shares or all to surviving parent</li> <li>4. A duly appointed executor or administrator of your estate</li> <li>5. Other next of kin</li> </ol>

### Payment Options

If you want the beneficiary to ...	Then ...
receive the insurance proceeds in one lump sum	<p>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<sup>®*</sup>, by check, or Electronic Funds Transfer (EFT).</p> <p><small>*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.</small></p>
receive the insurance proceeds in 36 equal monthly payments	<ul style="list-style-type: none"> <li>■ Write "36" under the Payment Option.</li> <li>■ Your beneficiary cannot change this payment option.</li> </ul>
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 that ...	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.	
is increasing or restoring SGLI	he or she must complete Section 4, <i>About Your Health</i> .	<ul style="list-style-type: none"> <li>■ Approve form if the responses to questions 4a through 4g are "No" and forward the form to payroll to change SGLI premium deductions.</li> <li>■ Send form to OSGLI if any answer to questions 4a through 4g are "Yes." Only inform payroll when approved by OSGLI.</li> </ul>
is reducing SGLI	<ul style="list-style-type: none"> <li>■ an application with health questions is required to increase coverage at a later date.</li> <li>■ if the member is married, the Branch of Service must provide written notification to his or her spouse that the member reduced coverage.</li> </ul>	Forward the form to payroll to change SGLI premium deductions.
is declining SGLI	<ul style="list-style-type: none"> <li>■ this will also cancel Family SGLI coverage—both spousal coverage and dependent child coverage—and Traumatic Injury Protection (TSGLI).</li> <li>■ if the member is married, the Branch of Service must provide written notification to his or her spouse that the member declined coverage.</li> </ul>	<ul style="list-style-type: none"> <li>■ Have the service member complete SGLV 8286A to end payment of Family spousal premiums. The service member does not need to complete a form to end payment of TSGLI premiums.</li> <li>■ Forward the form to payroll to change SGLI premium deductions.</li> </ul>
is married or gets married after completing this form	<ul style="list-style-type: none"> <li>■ Family SGLI automatically covers spouse.</li> <li>■ he or she must register their spouse in DEERS for payroll to deduct premiums.</li> <li>■ If the member wants to decline coverage or take a lesser amount of spousal coverage, the member must complete SGLV 8286A.</li> </ul>	<p>If applicable, forward the form to payroll to begin premium deductions for the spousal coverage.</p> <p>Forward the form to payroll to begin premium deductions for the spousal coverage, if applicable.</p>
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.	Attach the Supplemental Beneficiary Form to the 8286.
wants to designate an unusual beneficiary given their family circumstances	<ul style="list-style-type: none"> <li>■ while the member is free to designate anyone he or she chooses as beneficiary, the member must certify that he or she understands the designation is unusual and the person named will receive the benefit.</li> <li>■ if the member is married, the Branch of Service must provide written notification to his or her spouse that the member changed the designation.</li> </ul>	Have the member sign a paper with the following statement: I certify that I understand my beneficiary designation is unusual, and I intend <named beneficiary> to receive my insurance proceeds in the event of my death. I also understand that if I am married, my spouse will be notified that he/she is not my 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

**STATEMENT TO SUBSTANTIATE PAYMENT OF FAMILY SEPARATION ALLOWANCE (FSA)**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 37, U.S. Code, Section 427.  
**PRINCIPAL PURPOSE:** To evaluate member's application for FSA.  
**ROUTINE USES:** a. Serves as substantiating document for FSA payments and input into the member's pay account.  
 b. Provides an audit trail for validating propriety of payments and to assist in collecting erroneous payments.  
 c. Provides a record in service member's pay account and for safekeeping.  
**DISCLOSURE:** Disclosure of your social security number and other personal information is voluntary. However, if requested information is not provided, FSA will not be considered.

<b>1. NAME OF MEMBER</b> <i>(Last, First, Middle Initial)</i>	<b>2. GRADE</b>	<b>3. SOCIAL SECURITY NUMBER</b>	<b>4. BRANCH AND ORGANIZATION</b>
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**PART I - MEMBER COMPLETES THIS SECTION TO SUBSTANTIATE ENTITLEMENT TO FSA**

<b>5. TYPE II</b> <i>(X as applicable)</i> <input type="checkbox"/> FSA-T (Temporary) <input type="checkbox"/> FSA-R (Restricted) <input type="checkbox"/> FSA-S (Ship)	<b>6. COMPLETE CURRENT ADDRESS(ES) OF DEPENDENT(S)</b>
<b>7. DATE</b> <i>(DDMMYY)</i> <b>DEPARTED RESIDENCE TO UNIT HOME STATION</b> <i>(Mobilized Members)</i>	

**8. I CERTIFY TO THE FOLLOWING FACTS** *(X applicable box(es))*

a. I am not divorced or legally separated from my spouse.

b. My dependent child (children) was (were) not in the legal custody of another person when I received my military orders.

c. My dependent (other than my spouse; see line f. below) is not a member of the military service on active duty.

d. My sole dependent is not in an institution for a known period of over 1 year or a period expected to exceed 1 year.

e. I am claiming FSA for my parent(s) for whom I have a current and approved dependency status and am residing with, and I maintain a residence(s) for my dependent(s). I have assumed the liability and responsibilities thereof at the address(es) shown above, where I likely reside during periods of leave or such other times as my duty assignment may permit.

f. I am married to another military member currently serving on active duty and my spouse  was  was not residing with me immediately before being separated by execution of my military orders.  
 Spouse's SSN: \_\_\_\_\_ Branch and Component: \_\_\_\_\_

g. My last TDY or deployment, if any,  was  was not within the last 30 days from this TDY or deployment.

**9.** I understand that I must notify my commanding officer immediately upon any change in dependency status and if my sole dependent or all of my dependents move to or near this station or if my dependent(s) visit at or near this station for more than 90 continuous days (more than 30 continuous days in the case of FSA-T (Temp) or FSA-S (Ship) while I am in receipt of FSA.

<b>a. DATE</b> <i>(DDMMYY)</i>	<b>b. SIGNATURE OF MEMBER</b>
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**PART II - CERTIFYING OFFICER COMPLETES THE APPROPRIATE SECTION(S) BELOW**

**10. TYPE II - FSA-T.** Member has been ordered to and has performed temporary duty (TDY) at the location(s) shown below for more than 30 continuous days. This (these) location(s) is (are) outside a reasonable commuting distance from the member's permanent duty station (PDS pertains to active component) or the home of residence (HOR pertains to reserve component). A distance of 50 miles, one way, is normally considered to be within a reasonable commuting distance of a PDS or HOR. "Within a reasonable commuting distance" also may include distances of less than 50 miles and the time required to travel, under unusual conditions, does not exceed 1-1/2 hours. *(Attach a blank page for continuation if necessary.)*

a. LOCATION	b. INCLUSIVE DATES OF TDY/T <i>(From/To)</i>	c. NO. OF DAYS

**11. TYPE II - FSA-R.** Member departed (PCS/detached) from \_\_\_\_\_ on \_\_\_\_\_ *(Last permanent duty station)* *(DDMMYY)* and was on leave en route \_\_\_\_\_, proceed time \_\_\_\_\_, *(Inclusive leave dates - DDMMYY)* *(Inclusive dates)* and the member reported to \_\_\_\_\_ on \_\_\_\_\_ *(PDS)* *(DDMMYY)*. Transportation of dependent(s) is not authorized at government expense to this station or to a place near this station.

**12. TYPE II - FSA-S.** Member was serving on orders, on board ship, away from homeport commencing *(DDMMYY)* \_\_\_\_\_.

<b>a. NAME OF SHIP/UNIT</b>	<b>b. HOMEPORT</b>
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**13.** Travel performed under authority of orders \_\_\_\_\_, dated \_\_\_\_\_.

**14.** Member claiming Type II FSA, is receiving basic allowance for housing (BAH) (or residing in government type quarters) as a member with dependents or member married to a military member.

<b>15. DATE</b> <i>(DDMMYY)</i>	<b>16. CERTIFYING OFFICER</b>		
	a. TYPED NAME <i>(Last, First, Middle Initial)</i>	b. TITLE	
	c. ORGANIZATION	d. SIGNATURE	

**CHANGE OF HOMEPORT ARRIVAL  
TEMPORARY LODGING ALLOWANCE (TLA)  
INFORMATION SHEET**

NAME (Last, First, MI):	RANK/RATE:	SSN:
COMMAND:	UIC:	WORK PHONE:
ARRIVAL DATE:	TLA HOTEL:	
INITIALS:		
	The purpose of TLA is to <b>PARTIALLY</b> reimburse a member for more than normal expenses incurred while occupying temporary lodging accommodations.	
	FAMILY MEMBERS <b>MUST BE COMMAND-SPONSORED</b> prior to the effective date of orders.	
	TLA is payable in 10 or less day increments, with a paid receipt and TLA authorization, not to exceed 60 calendar days (including periods of TAD off the island) from the date of reporting. Waivers may be requested via letter to COMNAVBASE Pearl Harbor.	
	TLA to the member while on leave (prior to report date) or TAD off the island. If the member is TAD off the island, TLA may be paid only for family members who remain on island.	
	TLA is payable when staying with friends/relatives (meal allowance only) or in temporary lodging on the island of Oahu only.	
	Immediately after arrival to change of homeport, personnel arriving with their family members are required to register with the Navy Aloha Center within 72 hours for a housing assignment appointment and TLA authorization due to non-availability of government quarters. The member or a family member (with power of attorney) is required to have a copy of change of homeport certificate, and Page 2 (Record of Emergency Data).	
	Single and geographical bachelors attached to an Afloat command are <b>NOT</b> eligible to receive TLA.	
	The Navy Aloha Center and Housing Referral Office are located at 4825 Bougainville Drive, Honolulu HI 96818 (Bldg 2562) adjacent to Moanalua Service Center and can be contacted at 474-1800	
	All payments are made via EFT to the bank account where regular pay is deposited. EFT payments normally post to the bank account within 3 working days after claim submission	
	Member may submit TLA claim <b>NO EARLIER THAN</b> the last day of authorized hotel stay. Member must have the following documents when submitting claim to PSD Pearl Harbor. 1) Change of Homeport Certificate, 2) Travel Authorization Orders 3) Copy of Page 2, 4) TLA Authorization Letter from housing, 5) Arrival TLA Information Sheet, 6) Itemized hotel receipts with zero balance, 7) TLA worksheet, 8) Homeport change worksheet (PSD clerk will provide forms if member does not have)	
	The TLA clerk will update/start applicable station allowances (i.e. BAH and COLA). TLA is paid five to ten days upon receipt of all documentation.	
	All payments are made via EFT to the bank account where regular pay is deposited. EFT payments normally post to the bank account within <b>10 working days after claim submission</b>	
<p>“I have been briefed and understand the provisions regarding entitlement to Arrival TLA and my responsibilities as contained in COMNAVBASEPEARLINST 7220.2D and will promptly notify the command of any change in statutes affecting entitlement thereto.”</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Member’s Signature)</p>		
SL 1/2007		

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 5 U.S.C. Sections 404 -427, 5 U.S.C. Section 301, DoDFMR 7000.14-R, Vol. 7 Part A, and E.O. 9397.

**PRINCIPAL PURPOSE(S):** This record is used for reviewing, approving, and accounting for general purpose in house processing.

**ROUTINE USE(S):** Disclosures are permitted under 5 U.S.C. 552a(b), Privacy Act of 1974, as amended. In addition, information may be disclosed to any competent lawful authority when required by law.

**DISCLOSURE:** Voluntary; however, failure to furnish the information requested may result in non-processing of service member’s pays.

## TEMPORARY LODGING ALLOWANCE (TLA) WORKSHEET

NAME (Last, First, MI)	RANK/RATE	SSN
COMMAND REPORTING TO/FROM	NAME OF HOTEL	

### FAMILY MEMBERS ON STATION

NAME (Last, First, MI)	RELATIONSHIP	DATE OF BIRTH

**FOR ARRIVAL TLA:**

DATE MEMBER REPORTED TO PRESENT COMMAND: \_\_\_\_\_

DATE FAMILY MEMBER(S) REPORTED TO PRESENT COMMAND: \_\_\_\_\_

THIS IS THE \_\_\_\_\_ CLAIM

MEMBER MUST PRESENT TLA AUTHORIZATION FROM THE HOUSING OFFICE AND A PAID LODGING RECEIPT. A FAMILY MEMBER WHO IS FILING TLA DUE TO THE ABSENCE OF THE SPONSOR MUST HAVE A GENERAL OR SPECIAL POWER OF ATTORNEY SPECIFICALLY STATING TLA IS AUTHORIZED FOR PROCESSING.

**FOR DEPARTURE TLA:**

ACTUAL DATE OF DETACHMENT: \_\_\_\_\_

MEMBERS LIVING OFF-BASE MUST PRESENT A RENTAL RELEASE FROM THE LANDLORD OR REALTOR.

MEMBER LIVING ON-BASE MUST PRESENT A SIGNED STATEMENT FROM THE HOUSING OFFICE CERTIFYING THE DATE GOVERNMENT QUARTERS WERE VACATED.

**MEMBER'S STATEMENT:**

I HAVE INCLUDED HEREIN ALL LODGING RECEIPTS FOR TLA. I CERTIFY THAT I  AM /  AM NOT IN A PER DIEM STATUS. I UNDERSTAND

THAT IF I AM IN A TEMPORARY DUTY PER DIEM STATUS, ONLY MY FAMILY MEMBERS ARE ENTITLED TO TLA. I FURTHER CERTIFY THAT MY FAMILY MEMBERS AND I  DID /  DID NOT UTILIZE GOVERNMENT MESS FOR ANY MEALS DURING THIS PERIOD. MY TEMPORARY QUARTERS  DO /  DO NOT CONTAIN FACILITIES FOR PREPARING AND CONSUMING MEALS.

**WARNING:**

THE PENALTY FOR WILLFULLY MAKING FALSE CLAIM IS: MAXIMUM FINE OF \$10,000.00 OR MAXIMUM IMPRISONMENT FOR FIVE YEARS, OR BOTH (U.S. CODE, TITLE 18, SECTION 287). BE ADVISED THAT ALL CLAIMS ARE SCREENED AND THOSE SUSPECTED OF BEING FRAUDULENT ARE TURNED OVER TO THE NAVAL CRIMINAL INVESTIGATIVE SERVICE (NCIS).

**PRIVACY ACT STATEMENT:**

THIS STATEMENT IS PROVIDED IN COMPLIANCE WITH THE PROVISIONS OF THE PRIVACY ACT OF 1974 (PL 93-579) WHICH REQUIRES THAT FEDERAL AGENCIES MUST INFORM INDIVIDUALS WHO ARE REQUESTED TO FURNISH INFORMATION ABOUT THEMSELVES AS TO THE FOLLOWING FACTS CONCERNING THE INFORMATION REQUESTED.

1. AUTHORITY: 37 USC 1006
2. PRINCIPAL PURPOSE: TO PROVIDE INFORMATION REQUIRED TO LEGALLY PAY TEMPORARY LODGING ALLOWANCE (TLA).
3. ROUTINE USE: THE MEMBER PROVIDES INFORMATION ON COST AND TYPE OF LODGING WHICH IS USED TO COMPUTE ENTITLEMENT TO TLA. SUPPORTING DOCUMENTS ARE USED TO DETERMINE ELIGIBILITY AND AMOUNT OF ENTITLEMENT.
4. MANDATORY OR VOLUNTARY DISCLOSURE: VOLUNTARY. IF MEMBER DOES NOT PROVIDE INFORMATION, TLA CANNOT BE PAID.

MEMBER SIGNATURE	DATE
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**TLA CHART FOR OAHU MAY 01, 2012**

PERCENT	NUMBER OF FAMILY MEMBERS	MAX RATE	MEALS	LODGING
65%	MEMBER OR 1 DEPENDENT	\$196.95	\$81.90	\$115.05
100%	MEMBER AND 1 DEPENDENT	<b>\$303.00</b>	<b>\$126.00</b>	<b>\$177.00</b>
125%	MEMBER AND 1 DEPENDENT WITH 1 CHILD UNDER 12 YRS	\$378.75	\$157.50	\$221.25
135%	MEMBER AND 1 DEPENDENT WITH 1 CHILD OVER 12 YRS	\$409.05	\$170.10	\$238.95
150%	MEMBER AND 1 DEPENDENT WITH 2 CHILDREN UNDER 12 YRS	\$454.50	\$189.00	\$265.50
160%	MEMBER AND 1 DEPENDENT WITH 1 CHILD UNDER 12 AND 1 OVER 12 YRS	\$484.80	\$201.60	\$283.20
170%	MEMBER AND 1 DEPENDENT WITH 2 CHILDREN OVER 12 YRS	\$515.10	\$214.20	\$300.90
175%	MEMBER AND 1 DEPENDENT WITH 3 CHILDREN UNDER 12 YRS	\$530.25	\$220.50	\$309.75
185%	MEMBER AND 1 DEPENDENT WITH 2 CHILDREN UNDER 12 AND 1 CHILD OVER 12 YRS	\$560.55	\$233.10	\$327.45
195%	MEMBER AND 1 DEPENDENT WITH 1 CHILD UNDER 12 AND 2 CHILDREN OVER 12 YRS	\$590.85	\$245.70	\$345.15
200%	MEMBER AND 1 DEPENDENT WITH 4 CHILDREN UNDER 12 YRS	\$606.00	\$252.00	\$354.00
205%	MEMBER AND 1 DEPENDENT WITH 3 CHILDREN OVER 12 YRS	\$621.15	\$258.30	\$362.85
210%	MEMBER AND 1 DEPENDENT WITH 3 CHILDREN UNDER 12 AND 1 CHILD OVER 12 YRS	\$636.30	\$264.60	\$371.70
220%	MEMBER AND 2 CHILDREN UNDER 12 YRS AND 2 CHILDREN OVER 12 YRS	\$666.60	\$277.20	\$389.40