STATEMENT CERTIFYING NUMBER OF MONTHS
OF SURVIVOR BENEFIT PLAN (SBP) PREMIUMS PAID

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 73, subchapters II and III; DoD Instruction 1332.42, Survivor Annuity Program Administration; DoD Financial Management Regulation, Volume 7B, Chapter 45; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): For use by a retired member who disagrees with the number of months reported by DFAS that the member has credited toward paid-up SBP.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to provide necessary information will result in rejection of application without further action.

INSTRUCTIONS

Use this form if you disagree with the number of months that DFAS has credited you toward Paid-up SBP. The number of months can be found on your Retiree Account Statement (RAS).

DO NOT submit this form until you have been notified by DFAS of the number of months credited toward Paid-up SBP and only if you disagree with the number of months credited.

Section I: Self-explanatory.

Section II: Complete only if you have been on the Temporary Disability Retired List (TDRL).

Section III: Include both the number of months credited and the number of months you are claiming.

Section IV: DO NOT write in this area.

DO NOT send any additional documentation with this form. DFAS will notify you when and where to mail your supporting documentation, if required.

Send the completed form only to:
Defense Finance and Accounting Service, P.O. Box 7190, Attn: 2656-11, London, KY 40742-7130.

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SECTION I - MEMBER INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *(YYYYMMDD)*

4. ADDRESS *(Street, Apartment Number, City, State, and ZIP Code)*	5. TELEPHONE NUMBER *(Include area code)*
	6. EMAIL ADDRESS

SECTION II - ADDITIONAL INFORMATION

7. **RETIREMENT DATE** *(YYYYMMDD)*

8. **SINCE YOUR RETIREMENT, HAVE YOU HAD ANY OF THE FOLLOWING CHANGES?** *(X applicable block(s) and provide date(s).)*

☐	a. **MARITAL STATUS** *(If Yes, give date(s) (YYYYMMDD))*	☐	b. **DIVORCE/ANNULMENT** *(If Yes, give date(s) (YYYYMMDD))*
☐	c. **BIRTH OF CHILD** *(If Yes, give date(s) (YYYYMMDD))*	☐	d. **DEATH OF CHILD** *(If Yes, give date(s) (YYYYMMDD))*
☐	e. **DEATH OF SPOUSE** *(If Yes, give date(s) (YYYYMMDD))*	☐	f. **DEATH OF INSURABLE INTEREST BENEFICIARY** *(If Yes, give date(s) (YYYYMMDD))*

9. **HAVE YOU EVER BEEN ON THE TEMPORARY DISABILITY RETIRED LIST (TDRL)?** *(X one)*

	(If Yes, give dates (YYYYMMDD))	a. **FROM**	b. **TO**
☐ **YES**			
☐ **NO**			

10. **WHILE YOU WERE ON THE TDRL, DID YOU HAVE SBP COVERAGE?** *(X one)*

		a. **BENEFICIARY NAME** *(Last, First, Middle Initial)*	b. **DATE OF BIRTH** *(YYYYMMDD)*	c. **RELATIONSHIP**
☐ **YES**	*(If Yes, provide the following:)*			
☐ **NO**				

SECTION III - CERTIFICATION

I have been notified by the Defense Finance and Accounting Service that I have _____ months toward Paid-Up SBP. I certify that I have records which I must produce, if required, that substantiates that I have paid SBP or RCSBP premiums for _____ months.

I understand that upon receipt of this certification DFAS will review my retired pay account and will notify me of their findings.

I certify that the above statements are true and that I have actual records to substantiate my claim for ALL months of Paid-Up SBP that I am claiming - not just the difference.

11a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

SECTION IV - For DFAS Use Only - Do not write below this block

NOMR _____

NOMC _____

TDRL _____

DOBM _____ **HOLD** _____

CIOT _____

MMPP _____ **DLSTM** _____

Reset