VERIFICATION FOR SURVIVOR ANNUITY

PRIVACY ACT STATEMENT

AUTHORITY: Chapter 73, Title 10, U.S.Code, and E.O. 9397.
PRINCIPAL PURPOSE(S): To be used by surviving spouses, dependent children, surviving former spouses, and natural interest persons to apply for an annuity under the Retired Serviceman's Family Protection Plan (RSFPP), Survivor Benefit Plan (SBP), and/or Reserve Component Survivor Benefit Plan (RCSBP).
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, refusal to certify identifying information may hinder the validating process and cause difficulty in approving payment.

INSTRUCTIONS

Please verify that the information provided below is correct. Please provide any missing information and line through and correct any errors. After verifying the information provided, please sign the form below and return it to: **Defense Finance and Accounting Service (DFAS), U.S. Military Annuitant Pay, P.O. Box 7131, London, KY 40742-7131** or fax it to DFAS toll-free at **1-800-982-8459**. If you have questions or need assistance completing this form, please contact DFAS toll-free at **1-800-321-1080**.

1. DECEASED MEMBER DATA VERIFICATION

a. DECEASED MEMBER'S NAME *(Last, First, Middle Initial)*		b. SOCIAL SECURITY NUMBER	
c. DATE OF BIRTH *(YYYYMMDD)*	d. DATE OF DEATH *(YYYYMMDD)*	e. BRANCH OF SERVICE	f. RANK/RATE

2. CLAIMANT VERIFICATION

a. CLAIMANT'S NAME *(Last, First, Middle Initial)*		b. SOCIAL SECURITY NUMBER	
c. DATE OF BIRTH *(YYYYMMDD)*	d. TELEPHONE *(Include Area Code)*	e. CITIZEN OF *(Country)*	f. TYPE OF BENEFIT CLAIMED *(X all that apply)*

f. TYPE OF BENEFIT CLAIMED *(X all that apply)*
- ☐ SBP
- ☐ RCSBP
- ☐ RSFPP

g. RELATIONSHIP TO DECEDENT *(X one)*

☐ SPOUSE ☐ CHILD ☐ FORMER SPOUSE ☐ INSURABLE INTEREST

h. CORRESPONDENCE ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*

3. THE FOLLOWING SECTION APPLIES TO SPOUSE APPLICANTS ONLY

a. I CERTIFY THAT I WAS LEGALLY MARRIED TO THE MEMBER ON THE DATE OF DEATH: ☐ YES ☐ NO

(1) If YES, please verify date of marriage to member: *(If blank or incorrect, please provide correct marriage date)*	(2) If NO, please provide the date of divorce: *(YYYYMMDD)*

b. ARE THERE CHILDREN UNDER AGE 23 OR INCAPACITATED OF THE DECEASED MEMBER? ☐ YES ☐ NO
(If YES, please provide the following for each child:)

(1) Name *(Last, First, Middle Initial)*	(2) SSN	(3) Date of Birth *(YYYYMMDD)*

I understand that my annuity may be affected if I am receiving any other military survivor annuity of any kind from this deceased member or any other deceased member. I also understand that I am obligated to notify DFAS of any other annuities that might affect my entitlement.

c. ARE YOU RECEIVING ANY OTHER ANNUITY FROM DFAS BASED ON THE MILITARY RECORD OF ANY OTHER DECEASED MILITARY RETIREE? *(If YES, please provide the following:)* ☐ YES ☐ NO

(1) Name of Deceased Retiree *(Last, First, Middle Initial)*	(2) SSN	(3) SBP or RSFPP Coverage	(4) Monthly Benefit Amount
			$

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4. THE FOLLOWING SECTION APPLIES TO CHILD APPLICANTS ONLY									
a. ARE YOU MARRIED?		YES		NO	b. IF YOU ARE 18 YEARS OF AGE OR OLDER, ARE YOU A FULL-TIME STUDENT?		YES		NO

5. THE FOLLOWING SECTION APPLIES TO FORMER SPOUSE APPLICANTS ONLY	
a. DATE OF DIVORCE FROM DECEASED MEMBER *(YYYYMMDD)*	b. DATE OF REMARRIAGE *(If applicable) (YYYYMMDD)*

6. STATEMENT OF UNDERSTANDING - DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(This applies to spouse applicants only.)

The surviving spouse of a deceased member may be eligible for DIC, payable by the Department of Veterans Affairs (VA) if the member dies from a disease or injury incurred or aggravated in the line of duty while on active duty, active duty for training, or inactive duty for training. A spouse receiving DIC may not receive the full amount of an annuity under SBP, or RCSBP. In order to eliminate problems resulting from an annuity overpayment due to concurrent DIC payments, a statement of understanding is provided for your signature.

I UNDERSTAND THAT:

- I cannot receive both the full amounts of my annuity and DIC from the same deceased member.
- DFAS will establish my annuity in full if DIC or other survivor annuity payments data, as may be applicable, is not known at time of establishment.
- I am only entitled to the amount of the annuity that exceeds the DIC payment that may be payable, or the DIC only if that payment is greater than the annuity. Note: All SBP premiums paid will be refunded if the SBP annuity is not payable because the DIC payment is greater. In cases where the annuity is greater than the DIC payment, the cost will be recalculated and the difference between the SBP premiums paid and the recalculated cost will be refunded.
- If any overpayment of benefits occurs as the result of being awarded DIC, my signature on this statement authorizes the VA to repay DFAS the amount of the overpayment from the DIC payments to which I am or may become eligible.
- In the event I apply to the VA for DIC, I agree to notify DFAS of that application to include the address of the VA Office applied to, VA Claim number, and if applicable, the amount of award.

a. HAVE YOU APPLIED OR DO YOU INTEND TO APPLY TO THE VETERAN'S ADMINISTRATION (VA) FOR BENEFITS? *(If YES, please provide the following:)*		YES		NO
(1) VA Claim Number	(2) VA Monthly Award Amount **$**	(3) Mailing Address of VA Office Handling Your Account *(Street, City, State, ZIP Code)*		

7. CLAIM CERTIFICATION AND SIGNATURE *(To be completed by ALL applicants)*

The claimant or authorized representative must sign. The signature must be that of: the applicant; or for the annuitant by: the custodial natural parent or the legal representative; guardian; or custodian. Failure to sign will delay payment of the annuity.

a. SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE *(If applicable)*	b. DATE SIGNED *(YYYYMMDD)*

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