

PHYSICIAN CERTIFICATE FOR CHILD ANNUITANT

*Form Approved
OMB No. 0730-0011
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The public reporting burden for this collection of information is estimated to average 12 minutes 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 Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0730-0011), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. 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 FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO DFAS-DE/FRB, 6760 E. IRVINGTON PLACE, DENVER, CO 80279-6000.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C., chapters 71 and 73; E.O. 9397.

PRINCIPAL PURPOSE(S): The Survivor Benefit Plan Public Law 92425, September 1972, and the Retired Serviceman's Family Protection Plan (formerly the Uniformed Services Contingency Option Act of 1953, chapter 73, 10 U.S.C.), give requirements for coverage of children who are unmarried and incapable of self-support because of mental and/or physical incapacitation. If the incapacitation is temporary, we require certification every 2 years when the child annuitant is age 18 or over.

ROUTINE USE(S): This information may be disclosed to the Social Security Administration or Department of Veterans Affairs for current status of child.

DISCLOSURE: Voluntary; however, if DFAS does not receive this information, annuity payments stop. Disclosure of the Social Security Number (SSN) is voluntary; it is used to identify the annuitant.

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

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)*

<input type="checkbox"/>	(1) Incapable of self-support for the period _____
<input type="checkbox"/>	(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

<input type="checkbox"/>	physician or practitioner authorized to practice medicine in the state of _____
<input type="checkbox"/>	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>
c. SIGNATURE	d. DATE <i>(YYYYMMDD)</i>