PHYSICIAN CERTIFICATE FOR CHILD ANNUITANT

Form Approved
OMB No. 0730-0011
Expires Aug 31, 2003

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** *(Last, First, Middle Initial)*	**3. DATE OF BIRTH** *(YYYYMMDD)*	**4. ANNUITANT'S SSN**

5. BRIEF DESCRIPTION OF MEDICAL/PSYCHIATRIC DIAGNOSIS	**6. DATE CONDITION BEGAN** *(YYYYMMDD)*

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 *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)*

c. SIGNATURE	d. DATE *(YYYYMMDD)*
	

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