

United States Army Student Detachment

Student In-Processing

SOLDIER INFORMATION	
Name:	Report date:
Rank:	Grad/Completion date:
	Program: Component:

ADMINISTRATION CHECKLIST	PACKET RECEIVED DATE:
<input type="checkbox"/> PCS Orders and Amendments <input type="checkbox"/> (DD 93, January 2008) Record of Emergency Data <input type="checkbox"/> (SGLV 8286, June 2011) Service Members' Group Life Insurance Election and Certificate <input type="checkbox"/> DA Form 7415 (Exceptional Family Member Program (EFMP) Query Sheet) <input type="checkbox"/> (DA 31, September 1993) Request and Authority for leave (with control number) <input type="checkbox"/> United States Army Student Detachment Policy Letter Acknowledgement <input type="checkbox"/> (SF 312) Classified Information Nondisclosure Agreement <input type="checkbox"/> Contact TRICARE to update medical coverage (see toll free numbers enclosed) <input type="checkbox"/> (DA 705, November 2010) Army Physical Fitness Form <input type="checkbox"/> (DA Form 5960, September 1990) Basic Housing Allowance (MANDATORY) <input type="checkbox"/> (DD Form 1351-2, March 2011) Travel Voucher <input type="checkbox"/> (DA 2560) Advance Pay Certificate/Authorization <input type="checkbox"/> TLE (Temporary Lodging Expense) Work Sheet (with daily itemized lodging receipt) <input type="checkbox"/> TLA (Temporary Lodging Allowance; (OCONUS ONLY) (with daily itemized lodging receipts) <input type="checkbox"/> (DD 2367) OHA (OVERSEAS Housing Allowance; (OCONUS ONLY) <input type="checkbox"/> (DD 2556) MIHA (Move In Housing Allowance; (OCONUS ONLY) <input type="checkbox"/> Government Travel Card Program Statement of Understanding (CURRENT CARDHOLDER) <input type="checkbox"/> Government Travel Card Program Update your Information <input type="checkbox"/> Government Travel Card Application (MANDATORY IF NOT IN POSSESSION OF CARD) <input type="checkbox"/> Update ADPAAS (https://adpaas.army.mil) **print out screen to show it has been update** <input type="checkbox"/> Personally Procured Move (PPM) Settlements (formally known as DITY Moves) is process for re-imburement by your locally designated Transportation Offices (see enclosed instructions)	

For Use of Student Detachment Personnel Only

Arrival in DB date:
UIC:

Arrived in EMILPO date:
Sign-In Date:

HR ANALYST:	DATE:
PACKET FWD TO FINANCE NCOIC :	DATE:
PACKET PROCESSED BY:	DATE:
PACKET FWD TO MAIN FINANCE:	DATE:
REMARKS:	

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).

PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. For military personnel, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. For civilian personnel, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiancée), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death. It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME (Last, First, Middle Initial)		2. SSN	
3a. SERVICE/CIVILIAN CATEGORY <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> AIR FORCE <input type="checkbox"/> DoD <input type="checkbox"/> CIVILIAN <input type="checkbox"/> CONTRACTOR			b. REPORTING UNIT CODE/DUTY STATION
4a. SPOUSE NAME (if applicable) (Last, First, Middle Initial) <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		b. ADDRESS (include ZIP Code) AND TELEPHONE NUMBER	
5. CHILDREN a. NAME (Last, First, Middle Initial)	b. RELATIONSHIP	c. DATE OF BIRTH (YYYYMMDD)	d. ADDRESS (include ZIP Code) AND TELEPHONE NUMBER
6a. FATHER NAME (Last, First, Middle Initial)	b. ADDRESS (include ZIP Code) AND TELEPHONE NUMBER		
7a. MOTHER NAME (Last, First, Middle Initial)	b. ADDRESS (include ZIP Code) AND TELEPHONE NUMBER		
8a. DO NOT NOTIFY DUE TO ILL HEALTH	b. NOTIFY INSTEAD		
9a. DESIGNATED PERSON(S) (Military only)		b. ADDRESS (include ZIP Code) AND TELEPHONE NUMBER	
10. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)			



Prudential

Office of Servicemembers' Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

1. About You

Print Name (First, Middle, Last)

Rank, title or grade

Social Security Number

Duty Location

Branch of Service

2. About Your Coverage

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.				Lump sum
2.				Lump sum
3.				Lump sum
4.				Lump sum
Secondary				
1.				Lump sum
2.				Lump sum
3.				Lump sum
4.				Lump sum

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 JPMorgan Chase 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., JPMorgan Chase 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)

2323
Your weight

123
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"/> |

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

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

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) _____

Current Amount of SGLI _____ 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 _____	

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUERYING SHEET

For use of this form, see AR 608-75; the proponent agency is ACSIM.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC Section 301, Departmental Regulations; 10 USC 1071-1085; 10 USC Section 3013, Secretary of the Army; and Army Regulation 608-75, EFMP.

PRINCIPAL PURPOSE: To identify soldiers that have family members for enrollment in the EFMP.

ROUTINE USES: To federal, state, and local medical agencies in order to provide an exceptional family member with medical treatment when the Department of the Army does not have a suitable treatment facility.

DISCLOSURE: Disclosure of the requested information is mandatory. Failure to provide the information may result in disciplinary and/or administrative action. Additionally, failure to provide the information may result in an EFM not receiving necessary medical care.

1. NAME OF SOLDIER	2. RANK
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3. UNIT

4a. HOME ADDRESS	b. HOME PHONE NUMBER
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5a. DUTY ADDRESS	b. DUTY PHONE NUMBER
	c. FAX NUMBER

d. EMAIL ADDRESS

6. Do you have a family member (*child or adult*) with a physical, emotional, developmental, or intellectual disorder that requires special treatment, therapy, education, training, counseling, equipment, assistance or medical care above the level of a general practitioner? YES NO

7. If the answer to the above question is yes, is the family member enrolled in EFMP? YES NO

8. The EFMP works with the other military and civilian agencies to provide comprehensive, coordinated community support, educational, housing, personnel, and medical services to families with special needs. Enrollment in EFMP is mandatory and benefits the family by considering medical and special education needs in the military personnel assignment process. Medical needs are considered in the worldwide assignment process whereas special education needs are only considered in overseas assignments.

9. The above information is true and correct to the best of my knowledge.

a. SIGNATURE OF SOLDIER	b. DATE SIGNED (YYYYMMDD)
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DEPARTMENT OF THE ARMY
UNITED STATES ARMY STUDENT DETACHMENT
5450 STROM THURMOND BLVD ROOM 244
FORT JACKSON, SOUTH CAROLINA 29207

ATZJ-DBI-SD

MEMORANDUM OF UNDERSTANDING

SUBJECT: Policy Memorandum

I have read and understand the United States Army Student Detachment policy memorandums. I know that these memorandums are guidelines that I must follow while assigned to the Student Detachment, along with guidelines put in place by Human Resources Command-Advance Civil Schooling branch and my school or training agency.

<http://www.jackson.army.mil/sites/school/pages/248/In-Processing-Information>

_____ (Printed Name)
_____ (Signature)
_____ (Date)

CLASSIFIED INFORMATION NONDISCLOSURE AGREEMENT

AN AGREEMENT BETWEEN

AND THE UNITED STATES

(Name of Individual - Printed or typed)

1. Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to classified information. As used in this Agreement, classified information is marked or unmarked classified information, including oral communications, that is classified under the standards of Executive Order 12958, or under any other Executive order or statute that prohibits the unauthorized disclosure of information in the interest of national security; and unclassified information that meets the standards for classification and is in the process of a classification determination as provided in Sections 1.2, 1.3, and 1.4(e) of Executive Order 12958, or under any other Executive order or statute that requires protection for such information in the interest of national security. I understand and accept that by being granted access to classified information, special confidence and trust shall be placed in me by the United States Government.

2. I hereby acknowledge that I have received a security indoctrination concerning the nature and protection of classified information, including the procedures to be followed in ascertaining whether other persons to whom I contemplate disclosing this information have been approved for access to it, and that I understand these procedures.

3. I have been advised that the unauthorized disclosure, unauthorized retention, or negligent handling of classified information by me could cause damage or irreparable injury to the United States or could be used to advantage by a foreign nation. I hereby agree that I will never divulge classified information to anyone unless: (a) I have officially verified that the recipient has been properly authorized by the United States Government to receive it; or (b) I have been given prior written notice of authorization from the United States Government Department or Agency (hereinafter Department or Agency) responsible for the classification of the information or last granting me a security clearance that such disclosure is permitted. I understand that if I am uncertain about the classification status of information, I am required to confirm from an authorized official that the information is unclassified before I may disclose it, except to a person as provided in (a) or (b), above. I further understand that I am obligated to comply with laws and regulations that prohibit the unauthorized disclosure of classified information.

4. I have been advised that any breach of this Agreement may result in the termination of any security clearances I hold; removal from any position of special confidence and trust requiring such clearances; or the termination of my employment or other relationships with the Departments or Agencies that granted my security clearance or clearances. In addition, I have been advised that any unauthorized disclosure of classified information by me may constitute a violation, or violations, of United States criminal laws, including the provisions of Sections 641, 793, 794, 798, *952 and 1924, Title 18, United States Code, * the provisions of Section 783 (b), Title 50, United States Code, and the provisions of the Intelligence Identities Protection Act of 1982. I recognize that nothing in this Agreement constitutes a waiver by the United States of the right to prosecute me for any statutory violation.

5. I hereby assign to the United States Government all royalties, remunerations, and emoluments that have resulted, will result or may result from any disclosure, publication, or revelation of classified information not consistent with the terms of this Agreement.

6. I understand that the United States Government may seek any remedy available to it to enforce this Agreement including, but not limited to, application for a court order prohibiting disclosure of information in breach of this Agreement.

7. I understand that all classified information to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of the United States Government unless and until otherwise determined by an authorized official or final ruling of a court of law. I agree that I shall return all classified materials which have, or may come into my possession or for which I am responsible because of such access: (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me a security clearance or that provided me access to classified information; or (c) upon the conclusion of my employment or other relationship that requires access to classified information. If I do not return such materials upon request, I understand that this may be a violation of Section 793 and/or 1924, Title 18, United States Code, a United States criminal law.

8. Unless and until I am released in writing by an authorized representative of the United States Government, I understand that all conditions and obligations imposed upon me by this Agreement apply during the time I am granted access to classified information, and at all times thereafter.

9. Each provision of this Agreement is severable. If a court should find any provision of this Agreement to be unenforceable, all other provisions of this Agreement shall remain in full force and effect.

(Continue on reverse.)

10. These restrictions are consistent with and do not supersede, conflict with or otherwise alter the employee obligations, rights or liabilities created by Executive Order 12958; Section 7211 of Title 5, United States Code (governing disclosures to Congress); Section 1034 of Title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); Section 2302(b)(8) of Title 5, United States Code, as amended by the Whistleblower Protection Act (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that expose confidential Government agents), and the statutes which protect against disclosure that may compromise the national security, including Sections 641, 793, 794, 798, 952 and 1924 of Title 18, United States Code, and Section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. Section 783(b)). The definitions, requirements, obligations, rights, sanctions and liabilities created by said Executive Order and listed statutes are incorporated into this Agreement and are controlling.

11. I have read this Agreement carefully and my questions, if any, have been answered. I acknowledge that the briefing officer has made available to me the Executive Order and statutes referenced in this Agreement and its implementing regulation (32 CFR Section 2003.20) so that I may read them at this time, if I so choose.

SIGNATURE	DATE	SOCIAL SECURITY NUMBER <i>(See Notice below)</i>
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ORGANIZATION (IF CONTRACTOR, LICENSEE, GRANTEE OR AGENT, PROVIDE: NAME, ADDRESS, AND, IF APPLICABLE, FEDERAL SUPPLY CODE NUMBER) *(Type or print)*

WITNESS		ACCEPTANCE	
THE EXECUTION OF THIS AGREEMENT WAS WITNESSED BY THE UNDERSIGNED.		THE UNDERSIGNED ACCEPTED THIS AGREEMENT ON BEHALF OF THE UNITED STATES GOVERNMENT.	
SIGNATURE	DATE	SIGNATURE	DATE
NAME AND ADDRESS <i>(Type or print)</i>		NAME AND ADDRESS <i>(Type or print)</i>	

SECURITY DEBRIEFING ACKNOWLEDGEMENT

I reaffirm that the provisions of the espionage laws, other federal criminal laws and executive orders applicable to the safeguarding of classified information have been made available to me; that I have returned all classified information in my custody; that I will not communicate or transmit classified information to any unauthorized person or organization; that I will promptly report to the Federal Bureau of Investigation any attempt by an unauthorized person to solicit classified information, and that I (have) (have not) (strike out inappropriate word or words) received a security debriefing.

SIGNATURE OF EMPLOYEE	DATE
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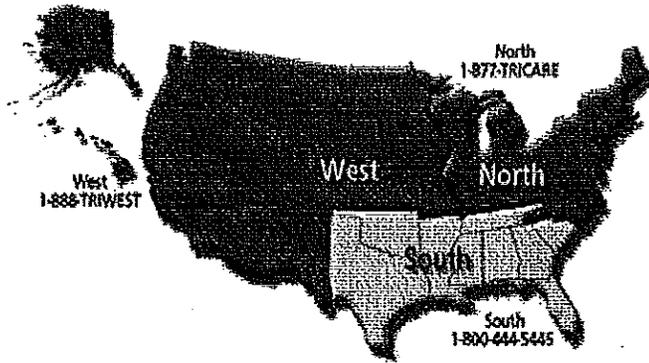
NAME OF WITNESS <i>(Type or print)</i>	SIGNATURE OF WITNESS
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NOTICE: The Privacy Act, 5 U.S.C. 552a, requires that federal agencies inform individuals, at the time information is solicited from them, whether the disclosure is mandatory or voluntary, by what authority such information is solicited, and what uses will be made of the information. You are hereby advised that authority for soliciting your Social Security Account Number (SSN) is Executive Order 9397. Your SSN will be used to identify you precisely when it is necessary to 1) certify that you have access to the information indicated above or 2) determine that your access to the information indicated has terminated. Although disclosure of your SSN is not mandatory, your failure to do so may impede the processing of such certifications or determinations, or possibly result in the denial of your being granted access to classified information.

* NOT APPLICABLE TO NON-GOVERNMENT PERSONNEL SIGNING THIS AGREEMENT.

TRICARE Phone Numbers

www.tricare.mil



North Region

Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, West Virginia, the District of Columbia, Virginia, and North Carolina.
1-877-TRICARE

South Region

South Carolina, Georgia, and Florida, Alabama, Mississippi, Tennessee, Oklahoma, Arkansas, Louisiana, Texas, excluding southwest corner.
1-800-444-5445

West Region

New Mexico, Arizona, Nevada and southwest corner of Texas, Colorado, Utah, Wyoming, Montana, Idaho, North Dakota, South Dakota, Nebraska, Kansas, Minnesota, Iowa, and Missouri, Hawaii, California, Washington, Oregon, and Alaska.
1-888-TRIWEST

Europe Region

Europe, Africa, Middle East, Azores, and Iceland.
1-888-777-8343

Puerto Rico, Virgin Islands, Latin America and Canada

Canada, Mexico, Central America, and the Caribbean basin.
1-888-777-8343

US Family Health Plan

1-800-74-USFHP; (1-800-748-7347); www.usfamilyhealthplan.org

United Concordia (TriCare dental Program)

www.tricaredentalprogram.com

Telephone Inquiries: (Enrolment and Billing)

1-888-622-2256

Hours: 0800-2000 ET

Monday-Friday

Dental form required to update in MEDPROS:

DD form 2813

Fax to:

Active duty: 210-295-0963

Active Reserve: 608-793-2960

National Guard; State Surgeon General

Active Duty and Active Reserve can choose to send to MEDPOS NCOIC to update as well.

USASD MEDPROS Update Capabilities

TriCare Remote Students:

The USASD can only update Vision, Dental, and Immunizations from Civilian doctors. Please contact the MEDPROS NCOIC for further information.

Additional forms Necessary for Updates:

Vision DA 7655

Immunizations: Shot Record

PHA: Contact MEDPROS NCOIC

Students Seen at a Military facility:

If your facility does not have access to update MEDPROS, USASD may be able to update your PHA. In addition to Vision, Dental, and Immunizations. Please contact the MEDPROS NCOIC about the requirements necessary to make the updates.

TriCare Remote Students and Students seen at a Medical Facility without MEDPROS Access:

To complete your Post Deployment Health Reassessment (PDHRA) call 1-888-734-7299

All Others contact your facility about their SOP on completing the PDHRA.

AUTHORIZATION TO START, STOP, OR CHANGE BASIC ALLOWANCE FOR QUARTERS (BAQ), AND/OR VARIABLE HOUSING ALLOWANCE (VHA) For use of this form, see AR 37-104-4; the proponent agency is ASA (FM)				PRIVACY ACT STATEMENT			
1. NAME (Last, First, MI)				AUTHORITY: 37 USC 403; Public Law 96-343; EO 9397.			
2. SOCIAL SECURITY NUMBER		3. GRADE		PRINCIPLE PURPOSE: To start, adjust or terminate military member's entitlement to basic allowance for quarters (BAQ) and/or variable housing allowance (VHA).			
4. TYPE OF ACTION				ROUTINE USE: To adjust member's military pay record, information may be disclosed to Army components, such as USAFAC, major commands, and other Army installations; to other DOD components; other federal agencies such as IRS, Social Security Administration and VA, GAO, members of Congress; State and local government; US and State courts, and various law enforcement agencies. Social Security Number (SSN) is used for positive identification.			
START		CANCEL		CHANGE		REPORT	
CORRECT		STOP		RECERTIFICATION			
5. DUTY LOCATION (Include Station, Name, City, State, and Zip Code)				6. DATE/ACTION (YYMMDD)		7. BAQ TYPE	
						WITH DEPENDENTS <input type="checkbox"/> PARTIAL <input type="checkbox"/>	
						WITHOUT DEPENDENTS <input type="checkbox"/>	
8. MARITAL/DEPENDENCY STATUS				9. QUARTERS ASSIGNMENT/AVAILABILITY			
<input type="checkbox"/> a. SINGLE		<input type="checkbox"/> b. MARRIED (see blocks (1), (2) & (3))		<input type="checkbox"/> c. DIVORCED (see blocks (1), (2) & (3))		<input type="checkbox"/> a. ADEQUATE (see block (1))	
<input type="checkbox"/> d. LEGALLY SEPARATED (see blocks (1), (2) & (3))		<input type="checkbox"/> e. DEPENDENT CHILD (see blocks (4), (5) & (6))		<input type="checkbox"/> c. TRANSIENT (see block (3))		<input type="checkbox"/> d. NOT AVAILABLE	
(1) Spouse/Former Spouse SSN		(2) Spouse/Former Spouse Duty Station		(3) Date of Marriage, Divorce/Separation		(1) QUARTERS NO. _____	
(2) Spouse/Former Spouse SSN		(2) Spouse/Former Spouse Duty Station		(3) Date of Marriage, Divorce/Separation		(2) FAIR RENTAL VALUE \$	
(4) Child In Custody of: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Other				(3) FROM: _____ TO: _____			
(5) If you check "OTHER" above, prepare DD Form 137 to establish dependency.				(4) <input type="checkbox"/> MEMBER ELECTION (Member in grade E7 and above) <input type="checkbox"/> COMMANDER DETERMINATION (Attached)			
(6) If child support received from another military member, complete (1), (2) & (3).							
10. DEPENDENTS/SHARERS (Continue on back if required)							
NAME OF DEPENDENT/SHARER		COMPLETE CURRENT ADDRESS (Include ZIP Code)			RELATIONSHIP		DOB OF CHILDREN
11. CERTIFICATION OF DEPENDENT SUPPORT							
<input type="checkbox"/> I certify that I provide, or am will to provide adequate support for the above named dependents. I am aware that failure to support the above named dependents may result in stopping BAQ and recouping BAQ for any prior periods/nonsupport.							
<input type="checkbox"/> IAW service regulations, I certify that the dependency status of my primary dependents, on whose behalf I am receiving BAQ, has not changed so as to affect my entitlement thereto for the period _____							
12. EXPENSES, IF AUTHORIZED, I AM REQUESTING VHA BASED ON							
My permanent duty station:		My dependent's location:		Both my permanent duty station and dependent's location.			
a. Monthly Expenses:		Member		Dependent		b. Sharer/Lease Information	
(1) Mortgage (PITI) or Rent						(1) Rental/Residential Address:	
(2) Insurance						(1) Landlord's Name and Address:	
(3) Other						(2) Effective Date: (3) Expiration Date: (2) Landlord's Phone No.	
TOTALS							
(4) Number of Sharers (show name(s) and address in block 10.)							
I certify ALL information regarding this authorization is correct. I will immediately notify the FAO/HRO of any changes in the information above, due to divorce, marriage, death, living in government quarters etc, which could affect by BAQ or VHA entitlement. IMPORTANT: Making a false statement or claim against the US Government is punishable by courts-martial. The penalty for willfully making a false claim or a false statement in connection with claims is a maximum fine of \$10,000 or imprisonment for 5 years, or both.							
13. MEMBER'S SIGNATURE				14. DATE		15. CERTIFYING OFFICER'S SIGNATURE	
						16. DATE	

TRAVEL VOUCHER OR SUBVOUCHER

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.

1. PAYMENT
 Electronic Fund Transfer (EFT)
 Payment by Check
SPLIT DISBURSEMENT: 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.
NOTE: A split disbursement is only necessary when a GTCC is used while on official travel for the Government.
 Pay the following amount of this reimbursement directly to the Government Travel Charge Card contractor: \$ _____

2. NAME (Last, First, Middle Initial) (Print or type) _____ **3. GRADE** _____ **4. SSN** _____

5. TYPE OF PAYMENT (X as applicable)
 TDV Member/Employee
 PCS Other
 Dependent(s) DLA

6. ADDRESS. a. NUMBER AND STREET _____ **b. CITY** _____ **c. STATE** _____ **d. ZIP CODE** _____

7. DAYTIME TELEPHONE NUMBER & AREA CODE _____ **8. TRAVEL ORDER/AUTHORIZATION NUMBER** _____

9. PREVIOUS GOVERNMENT PAYMENTS/ADVANCES _____

10. FOR D.O. USE ONLY
 a. D.O. VOUCHER NUMBER _____
 b. SUBVOUCHER NUMBER _____

11. ORGANIZATION AND STATION _____

12. DEPENDENT(S) (X and complete as applicable)
 ACCOMPANIED UNACCOMPANIED

13. DEPENDENTS' ADDRESS ON RECEIPT OF ORDERS (Include Zip Code)

a. NAME (Last, First, Middle Initial) _____ b. RELATIONSHIP _____ c. DATE OF BIRTH OR MARRIAGE _____

14. HAVE HOUSEHOLD GOODS BEEN SHIPPED? (X one)
 YES NO (Explain in Remarks) _____

15. ITINERARY

a. DATE	b. PLACE (Home, Office, Base, Activity, City and State; City and Country, etc.)	c. MEANS/MODE OF TRAVEL	d. REASON FOR STOP	e. LODGING COST	f. POC MILES
DEP					
ARR					
DEP					
ARR					
DEP					
ARR					
DEP					
ARR					
DEP					
ARR					
DEP					
ARR					
DEP					
ARR					

16. POC TRAVEL (X one) OWN/OPERATE PASSENGER

17. DURATION OF TRAVEL
 12 HOURS OR LESS
 MORE THAN 12 HOURS BUT 24 HOURS OR LESS
 MORE THAN 24 HOURS

18. REIMBURSABLE EXPENSES

a. DATE	b. NATURE OF EXPENSE	c. AMOUNT	d. ALLOWED

18. GOVERNMENT/DEDUCTIBLE MEALS

a. DATE	b. NO. OF MEALS	a. DATE	b. NO. OF MEALS

20.a. CLAIMANT SIGNATURE _____ **b. DATE** _____

c. REVIEWER'S PRINTED NAME _____ **d. SIGNATURE** _____ **e. TELEPHONE NUMBER** _____ **f. DATE** _____

21.a. APPROVING OFFICIAL'S PRINTED NAME _____ **b. SIGNATURE** _____ **c. TELEPHONE NUMBER** _____ **d. DATE** _____

22. ACCOUNTING CLASSIFICATION _____

23. COLLECTION DATA _____

24. COMPUTED BY _____ **25. AUDITED BY** _____ **26. TRAVEL ORDER/AUTHORIZATION POSTED BY** _____ **27. RECEIVED (Payee Signature and Date or Check No.)** _____ **28. AMOUNT PAID** _____

ADVANCE PAY CERTIFICATION/AUTHORIZATION

Privacy Act Statement

AUTHORITY: 37 U.S.C. 1006 et seq; E.O. 9397 November 1943 (SSN).

PRINCIPAL PURPOSES: To document a member's request for, and subsequent authorization of, an advance of pay to meet extraordinary expenses incident to a PCS move. It is also used to inform the member of the purposes and restrictions of such advances, and to establish repayment schedules.

ROUTINE USES: Information collected on this form becomes part of the Joint Uniform Military Pay System (JUMPS), and Reserve component pay systems and is subject to all of the routine disclosures which are more fully described in Service regulations. Routine recipients of JUMPS disclosures include, but are not limited to, Red Cross, State and local government for tax and welfare purposes.

DISCLOSURE: Voluntary; however, failure to provide the SSN will result in denial of payment since it is used to identify you for pay purposes.

PART I. REQUEST

1. NAME (Last, First, Middle Initial)		2. SOCIAL SECURITY NO.	3. GRADE
4. I REQUEST:		5. I REQUEST A REPAYMENT SCHEDULE OF:	6. I REQUEST PAYMENT OF THE ADVANCE PAY:
a. ONE MONTH ADVANCE PAY (See Policy Guidance on reverse.)	a. 12 MONTHS OR LESS (Specify number of months)	a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING TO MY NEXT PDS.	
b. MORE THAN 1 MONTH BUT LESS THAN 3 MONTHS BASIC PAY LESS DEDUCTIONS (Parts II and V must be completed.) (Specify amount) \$	b. 13 - 24 MONTHS (Parts II and V must be completed regardless of pay grade. NOTE: Repayment schedule cannot exceed member's date of separation.) (Specify number of months)	b. 31 - 90 DAYS BEFORE MY PCS (Parts II and V must be completed.)	
		c. 61 - 180 DAYS AFTER ARRIVAL AT MY PDS (Parts II and V must be completed.)	

PART II. CERTIFICATION OF EXPENSES (Actual or Anticipated) (Continue in Item 23 on reverse if necessary.)

7. EXPENSE	8. AMOUNT	10. EXPLANATION OF THE CIRCUMSTANCES WHERE GREATER-THAN-NORMAL EXPENSES MIGHT BE INCURRED OR CIRCUMSTANCES REQUIRING AN EARLY OR LATE PAYMENT OF ADVANCE PAY (Up to 90 days before and 180 days after).
a.	\$	
b.	\$	
c.	\$	
d.	\$	
e.	\$	
f.	\$	
9. TOTAL	\$ 0.00	

PART III. JUSTIFICATION FOR MORE THAN 12 MONTHS PAYBACK

(Justification must demonstrate that severe hardship would result if the advance is paid back in 12 months)

11. NO. OF DEPENDENTS	12. LIST SPECIFICS OF YOUR FINANCIAL SITUATION, INCLUDING OUTSTANDING DEBTS AND MONTHLY PAYMENT AMOUNTS THAT INDICATE A SEVERE HARDSHIP IN REPAYING THE ADVANCE IN THE NORMAL 12-MONTH TIME PERIOD (Continue in Item 23 on reverse if necessary.)

PART IV. MEMBER CERTIFICATION

Penalty: The penalty for willfully making a false claim/statement is a maximum of \$10,000 or maximum imprisonment of five years, or both (U.S. Code, Title 18, Section 287).

If I am separated prior to my ETS, I consent to withholding from current pay, final pay, or any other money due me to satisfy this indebtedness. I further consent to such withholding at a rate sufficient to satisfy this indebtedness no later than my separation, and understand that this could result in the withholding of 100% of any current pay, final pay, or other money due me.

I have read and understood the policy on advance pay incident to a PCS contained on the reverse of this form. I hereby certify that the intended use of these funds meets the stated purpose. I have attached one copy of my PCS orders or assignment notification.

13. SIGNATURE	14. DATE (YYMMDD)

PART V. APPROVAL OF MEMBER'S COMMANDER

15. I HEREBY APPROVE THIS REQUEST FOR ADVANCE PAY OF:	16. WITH LIQUIDATION OVER:	17. AND PAYMENT OF THIS ADVANCE:
a. ONE MONTH BASIC PAY LESS DEDUCTIONS	a. 12 MONTHS OR LESS (Specify number of months)	a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING AT PDS
b. AN AMOUNT SPECIFIED NOT TO EXCEED 3 MONTHS BASIC PAY LESS DEDUCTIONS (Specify amount) \$	b. 13 - 24 MONTHS (Specify number of months)	b. NOT PRIOR TO _____ (date) WHICH IS 31 - 90 DAYS BEFORE PCS
		c. 61 - 180 DAYS AFTER REPORTING TO NEW PDS
18. APPROVING OFFICIAL NAME (Last, First, Middle Initial)	19. SIGNATURE OF OFFICIAL	
20. TITLE	21. GRADE	22. DATE (YYMMDD)

Claim for Temporary Lodging Expense

Data required by the Privacy Act of 1974 Authority: JFTR, par U5700. Principle Purpose: To establish the amount payable for Temporary Lodging Expense Allowance. Routine Uses: Reference is used to substantiate payment of Temporary Lodging Expense Allowance. DISCLOSURE: Mandatory. Failure to provide information will result in the loss of requested revenue.

Rank	Name (last name first)	SSN	Home Phone
Mailing Address: Number & Street		City/State	Zip Code
Current Unit Assignment			Unit Phone

Marital Status (circle one): Single Divorce Married Dual Military	If Military, Spouse's SSN:	Spouse's Current Duty Station
--	----------------------------	-------------------------------

Did you stay in off post lodging: Yes or No Statement of non-availability #	(Without an SNA# from housing you are only authorized reimbursement for the on-post rate)
--	---

LIST DEPENDENTS YOU ARE CLAIMING TLE FOR:

Name	Relationship	Date of Marriage	Date of Birth

Date HHG Picked Up	Did you do a DITY move? Yes or No
Date HHG Delivered	If Yes, what date?

LODGING INFORMATION

PCS VOUCHER, ORIGINAL LODGING RECEIPTS, AND A FULL COPY OF ORDERS MUST BE ATTACHED TO THIS FORM.

I hereby certify that I was required to obtain temporary lodging for the following days:

DAY	Date	Location of Lodging (City & State)	Daily Lodging Costs	# Persons Claimed		
				SM	Over 12	Under 12
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Date terminated quarters (if applicable):
Date assigned quarters (if applicable):
Departure date from old duty station:
Arrival date at new duty station:

Signature of Service Member	Date:
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This payment will be made electronically to your current direct deposit account.

Signature of Finance Clerk	Date:	Time:
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INDIVIDUAL OVERSEAS HOUSING ALLOWANCE (OHA) REPORT				INTERAGENCY REPORT CONTROL NUMBER 0374-DOD-AR	
<i>Before completing, read Privacy Act Statement and Warning on reverse side.</i>				REPORT CONTROL SYMBOL DD-P&R(AR)1697	
PART A - IDENTIFICATION AND HOUSING INFORMATION					
1. SERVICEMEMBER			3. SERVICEMEMBER'S RESIDENCE ADDRESS (Street, Apt. No., City, Country)		
a. NAME (Last, First, Middle Initial)			4. EFFECTIVE DATE OF LEASE/RENTAL/SALE AGREEMENT (YYYYMMDD)		
b. PAY GRADE		c. SSN			
d. DUTY STATION OR HOMEPORT			5. IN WHAT CURRENCY IS YOUR RENT OR MORTGAGE PAID? (X one) (See Instructions on reverse side if you pay rent three or more months in advance.)		
(1) Station Name					
(2) City			a. LOCAL CURRENCY (Specify name of currency. Report amount in Item 6.)		
(3) Country			b. U.S. DOLLARS		
(4) Duty Phone			6. X THE APPROPRIATE BOX TO INDICATE WHETHER YOUR RESIDENCE IS LEASED OR OWNED AND GIVE THE MONTHLY RENTAL AMOUNT OR THE PURCHASE PRICE IN THE CURRENCY YOU SPECIFIED IN QUESTION 5.		
2. ARE YOU ENTITLED TO A COST-OF-LIVING OR OVERSEAS HOUSING ALLOWANCE FOR DEPENDENTS RESIDING ELSEWHERE? (X one)					
YES (Specify location)			a. LEASED/RENTED (Enter monthly rent below. If sharing, report TOTAL rent, not your share.)		
NO or NOT APPLICABLE			b. OWNED (Enter original purchase price. Include only cost of home, EXCLUDE closing costs, taxes, etc.)		
HOMEOWNERS, SKIP QUESTION 7 AND GO DIRECTLY TO QUESTION 8.					
7. UTILITIES (Excluding telephone) (X appropriate block)			8. TO DETERMINE IF YOU ARE A "SHARER" FOR HOUSING ALLOWANCE PURPOSES, ENTER AN X IN THE BOX AT LEFT FOR EACH CATEGORY OF INDIVIDUAL OCCUPYING YOUR RESIDENCE. FOR EACH CATEGORY YOU X, ENTER THE NUMBER REQUESTED IN THE BOX AT RIGHT, THEN RECORD THE TOTAL IN THE BOX AT THE BOTTOM. (NOTE: Do not count dependents unless covered by category c.)		
a. I SEPARATELY PAY FOR ALL UTILITIES. NONE ARE INCLUDED IN RENTAL/LEASE AGREEMENT WITH LANDLORD.			X a. MYSELF 1		
b. I DO NOT SEPARATELY PAY FOR ANY UTILITIES (excluding telephone). ALL UTILITIES ARE INCLUDED IN RENTAL/LEASE AGREEMENT AND PAID BY LANDLORD.					
c. I SEPARATELY PAY FOR SOME UTILITIES (excluding telephone) AND SOME ARE INCLUDED IN RENTAL/LEASE AGREEMENT WITH LANDLORD. (Complete items (1) - (5) below indicating utilities/services of which your landlord provides the MAJORITY.)			b. SPOUSE WHO IS ALSO A SERVICEMEMBER (Enter "1")		
(1) Electricity			c. SPOUSE OR OTHER DEPENDENT WHO IS A FEDERAL CIVILIAN EMPLOYEE ENTITLED TO LIVING QUARTERS ALLOWANCE (Enter number)		
(2) Heating			d. OTHER SERVICEMEMBERS ENTITLED TO A HOUSING ALLOWANCE (Enter number)		
(3) Air conditioning (X if window units used and landlord provides electricity.)			e. EXCLUDING DEPENDENTS, ANY OTHERS NOT COVERED ABOVE WHO PAY A PORTION OF THE RENT, MORTGAGE, AND/OR UTILITIES (Enter number)		
(4) Water or Sewer			TOTAL (Ba through e) (If result exceeds "1", you are considered a "sharer".) 1		
(5) Trash Disposal					
9. If Block 8.b. or 8.d. is marked, report their full name(s), Social Security Number(s) and Branch of Service in "Remarks" on reverse.					
PART B - CERTIFICATIONS					
10. SERVICEMEMBER. I certify that:			11. HOUSING OFFICER or APPROPRIATE OFFICIAL.		
a. The information I have reported is true and correct.			I have reviewed and verified the member's lease/rental/sale agreement and information from it was properly reported.		
b. I will immediately inform my commanding officer if any changes occur to the information I have reported.			a. MIHA/MISCELLANEOUS PAYMENT AUTHORIZED? (X one)		
c. The attached copy of my housing lease/rental/sale agreement (or certification from landlord) is true and correct, if applicable.			(1) Yes (2) No.		
d. I have read the overseas housing allowance briefing sheet provided by my commander or authorized representative, if applicable.			If Yes, entitlement is:		(a) Initial (b) Subsequent
e. SIGNATURE			b. SIGNATURE		c. DATE SIGNED (YYYYMMDD)
f. DATE SIGNED (YYYYMMDD)			d. TITLE		
12. CERTIFYING OFFICIAL. I have reviewed this action and certify the entitlement. If applicable to this action, member has read the overseas housing allowance briefing sheet and is aware of his/her entitlements and responsibility to report any changes.					
a. TYPE HOUSING ALLOWANCE ACTION (X one)			b. MIHA/MISCELLANEOUS ENTITLEMENT (X one)		
(1) Start	(3) Stop	(5) *Cancel	(1) Initial	(2) Subsequent	(3) None
(2) Change	(4) Correct	(6) *Report	c. EFFECTIVE DATE OF ACTION (YYYYMMDD)		
*For Air Force use only					
d. DOES MEMBER HAVE COMMAND-SPONSORED DEPENDENTS IN AREA OF PERMANENT DUTY STATION?			(1) Yes (2) No		
e. SIGNATURE			f. TITLE		g. DATE SIGNED (YYYYMMDD)

MOVE-IN HOUSING ALLOWANCE CLAIM FOR PERSONNEL OCCUPYING PRIVATELY LEASED/OWNED QUARTERS OVERSEAS <i>(Read Warning, Privacy Act Statement, and Instructions on reverse before completion)</i>			INTERAGENCY REPORT CONTROL NUMBER 0370-DOD-AR
			REPORT CONTROL SYMBOL DD-P&R(AR)1834
PART A - SERVICEMEMBER IDENTIFICATION AND RESIDENCE INFORMATION			
1. NAME <i>(Last, First, Middle Initial)</i>		2. GRADE	3. SOCIAL SECURITY NUMBER
4. DUTY LOCATION OR HOMEPORT		5. RESIDENCE ADDRESS <i>(Street, Apt. No., City, Country)</i>	
a. STATION NAME		b. LOCATION CODE <i>(Official Use)</i>	
c. CITY	d. COUNTRY	e. DUTY TELEPHONE NO.	
PARTS B - C - EXPENSES ASSOCIATED WITH OCCUPYING RENTED/OWNED QUARTERS			
a. EXPENSE ITEMS <i>(List all expense items in Parts B and C below. Enter "None" if appropriate. If a sharer, only one sharer may report an expense item. Report all amounts in dollars and cents. Refer to Instructions and Appendix N, JFTR, to determine what can and cannot be reported.)</i>		b. AMOUNT CLAIMED <i>(If payment made in foreign currency, convert to dollars at actual conversion rate.)</i>	c. AMOUNT ALLOWED <i>(If certifier excludes any amount, provide explanation on separate sheet.) (Official Use)</i>
PART B - RENT-RELATED EXPENSES (Not applicable to homeowners)			
6. PART B SUBTOTAL <i>(Official Use)</i>		→	0.00
PART C - SECURITY-RELATED EXPENSES (Allowed only in selected areas. See Appendix N.)			
7. PART C SUBTOTAL <i>(Official Use)</i>		→	0.00
PART D - REIMBURSEMENT TO MEMBER (Official use only. Servicemember - skip to Part E.)			
8. AMOUNT FROM LINE 6			0.00
9. AMOUNT FROM LINE 7			0.00
10. AMOUNT DUE MEMBER <i>(Sum of Lines 8 and 9)</i>			\$0.00
PART E - CERTIFICATIONS			
11. SERVICEMEMBER. I certify that the information reported in Parts A - C is true and correct.			
a. SIGNATURE		b. DATE SIGNED (YYYYMMDD)	
12. HOUSING OFFICER OR DESIGNATED AUTHORIZING/APPROVING OFFICIAL. I have reviewed this claim and certify that information was properly reported. I have entered monthly rent <i>(in dollars using Part B conversion rate, if appropriate)</i> and total sharers from member's DD Form 2367. <i>(If homeowner, report "rent" as original purchase price divided by 120.)</i>			
a. RENT	b. TOTAL SHARERS	c. TITLE	
d. SIGNATURE		e. DATE SIGNED (YYYYMMDD)	



**DEPARTMENT OF DEFENSE
STATEMENT OF UNDERSTANDING
GOVERNMENT TRAVEL CHARGE CARD PROGRAM**

1. I certify that I have read the Department of Defense (DoD) Government Travel Charge Card policy and procedures in DoDFMR 7000.14-R, VOL 9, CH 3 (http://www.defenselink.mil/comptroller/fmr/09/09_03.pdf). I understand that the Government Travel Charge Card Program is designed to improve the management, efficiency, and control of government travel. I also understand that I am authorized to use the card only for those necessary and reasonable expenses incurred by me for official travel. I will abide by these instructions issued by the Department.
2. The above limitation on card usage also applies to automated teller machine (ATM) withdrawals. The amount of cash withdrawals may not exceed the cash limits established on the card. If my account is not delinquent and my government travel orders authorize a larger advance, I can request an increase in the ATM limit through the Agency Program Coordinator (APC). I will, however, endeavor to charge expenses to the account wherever feasible rather than use cash withdrawals.
3. I understand the Department's policy requires mandatory use of split disbursement for all outstanding charges on the travel card for military personnel and civilian personnel where labor bargaining obligations have been met.
4. I understand that the issuance of this charge card to me is an extension of the employee/employer relationship and that I am being specifically directed to:

- Abide by all rules and regulations with respect to the charge card.
- Use the charge card only for official travel
- Pay all charges upon receipt of the monthly billing statement through prompt filing of travel vouchers and election of split disbursement.
- Notify the APC of any problems with respect to my usage of the charge card.
- Notify the card contractor and the APC if my charge card is lost or stolen.

(Card applicant must initial all the above provisions.)

I also understand that failure on my part to abide by these rules or otherwise misuse the card may result in disciplinary action being taken against me. I also acknowledge the right of the travel card contractor and/or the APC to revoke or suspend my travel card privileges if I fail to abide by the terms of this agreement or the cardholder agreement with the travel card contractor.

(Applicant's Signature)

(Supervisor's Signature)

CITI Government Travel Card

To update your government travel card information

1. Call Citi @ 1-800-200-7056, provide your new address, business, and residence phone number.
2. Please provide Student Detachment with the following information to transfer your account to our hierarchy level.
Rank/Name _____ SSN _____
Travel Card Account _____ Expiration date _____
Address _____
AKO Email Address _____
3. Incomplete forms will not be processed. A completed form must be on file at Student Detachment in order for the Travel Card to be activated.
4. Do not destroy your card. Each time you PCS: please see your gaining unit's Agency Program Coordinator.
5. For travel card questions, please contact Student Detachments' Agency Program Coordinator (803)751-5372.



Individually Billed Account Travel Card Set Up Form

Citibank[®] Government
Travel Card Program

Instructions:

This form must be completed by both the Department of Defense employee and the Agency Program Coordinator (APC). Use this form to apply for a new Individually Billed Card Account to be used by a Department of Defense employee. Information collected on this application is subject to the Privacy Act of 1974 (5 U.S.C. 552a) and applicable agency regulations. Questions? Contact Commercial Card Services toll-free 1-800-200-7056 from the U.S. and Canada or, if dialing from international locations, call collect 757-852-9076.

Date:	
Attention:	
Fax:	866-671-5910 605-338-6746

Section I: Cardholder Information (* = Required Fields)

1. Cardholder Name	Provide first, middle and last name of the applicant as it should appear on the card (maximum of 19 characters)											
2. Cardholder Primary Address	Mail to Attention:											
	Primary Address						Home Mailing Address (No Post Office Box)					
	A physical address must also be provided if a P.O. Box is your primary mailing address. Enter this address in the section titled "Secondary Address". Applications providing only a P.O. Box will not be processed. For APO/FPO addresses only a physical address is not required.											
	Address Type						<input type="checkbox"/> Alternate Mailing Address <input type="checkbox"/> Physical Mailing Address					
	Address Line 1*			Address Line 1			Address Line 2			Address Line 2		
	Address Line 2			Address Line 2			City or APO / FPO			State		
	City or APO / FPO			State			City or APO / FPO			State		
Zip/Postal Code*			Country			Zip/Postal Code			Country			
Commercial Office Phone*			Home Phone*			Email Address:						
3. Cardholder SSN												
4. Date of Birth (mm/dd/yyyy)												
5. Employment Status	<input type="checkbox"/> Active <input type="checkbox"/> Reserve <input type="checkbox"/> Guard <input type="checkbox"/> Civilian						6. Rank or Grade					

Section II: Cardholder Signature & Agreement (To be completed by employee. * = Required fields)

7. Signature & Agreement	By signing below, I: (i) acknowledge I have read the Citibank Department of Defense Services Travel Card Program Cardholder Agreement; (ii) agree to be bound by the terms and conditions as set forth in the Agreement; and (iii) understand that only the Department of Defense may request particular Authorization Parameters (Section III). This application is for a Department of Defense Travel Card account, which may be standard or restricted, as described in the Cardholder Agreement. I expressly agree to accept whichever type of account is established. Pursuant to requirements of law, including the U.S.A. Patriot Act, the bank is required to request additional information to verify your identity.											
	7. Applicant's Signature:						8. Date:					
	9. Consumer Report Authorization* (select one)			A. _____ I, as the cardholder, authorize the bank to obtain credit reports on me as described in the agreement			B. _____ I, as the cardholder, DO NOT authorize the bank to obtain credit reports on me. Therefore, I will not be eligible for a standard card.					
	10. Approving Supervisor's Signature:						11. Date:					

Section III: Account Specifications (To be completed by APC. * = Required fields)

12. Account Specifications	<input type="checkbox"/> APC Restricted Account Activation / Deactivation Information:			Date to Activate (mm/dd/yyyy):			Date to Deactivate (mm/dd/yyyy):					
	13. Plastic type* (select one)			<input type="checkbox"/> Government Standard <input type="checkbox"/> Quasi-Generic			14. Delivery* (select one)			<input type="checkbox"/> Standard <input type="checkbox"/> Expedited (\$20 delivery fee)		
	15. Central Account Number											

Section IV: Reporting Parameters (To be completed by APC. * = Required fields)

16. Account Hierarchy	Specify the complete account Hierarchy Level (HL) number that pertains to your organization										
	HL1	HL2	HL3	HL4	HL5	HL6	HL7				

Section V: Authorization (To be completed by APC. * = Required fields)

17. Authorized APC	By signing below, I hereby authorize, on behalf of the Agency/Organization Indicated above, that a Government Card be issued to the employee named in Section I of this application. PLEASE RETAIN A COPY FOR YOUR RECORDS.										
	APC Name (type or print)*			Signature*			Date*				
	Address Line 1*			Address Line 2*							
	City or APO/FPO*			State*			Zip / Postal Code*				
	Country*			Commercial Fax*			Email Address*				

Global Transaction Services

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PPM SETTLEMENT INSTRUCTIONS

PPMs are to be settled by the local transportation office, regardless of branch of service. Check block 4h of the DD 2278 for your responsible transportation office. This also applies to postal and storage reimbursements.

If there is any confusion on where to take/send your documents log on to www.move.mil.

Click on "DOD service member"

Click "locator maps"

Click "transportation office"

Choose your state

Choose the transportation office you feel is closest. All of their contact information is provided.

PPM packets should include the documents listed below along with this checklist:

DD Form 2278 – See block 4h for local processing station

DD Form 1351-2 (Travel Voucher) – with blocks 4 thru 11, and 20 completed.

Weight tickets - Loaded and empty tickets must include: **The identity of the vehicle weighed, the member's name and weigh master's signature.**

Advance Voucher – **Only if you received an advance payment for the PPM.**

Expense Claim Form - *Completed and signed.*

CLAIMABLE expenses include rental vehicles, packing materials, gas, tolls, etc.

NOT CLAIMABLE include but is not limited to, tow bars, auto transporters, INSURANCE, SALES TAX, FOOD AND LODGING.

Truck/Trailer Rental Receipts – Submit receipts for the pick up and turn-in.

Receipts for claimable expenses.

If you are located more than 50 miles away from Fort Jackson, SC, you may log on to www.move.mil to submit your claim.