

# CADET DD93 and SGLV DATA

Use Adobe Acrobat Reader on a PC to complete this page. Do NOT use a MAC/Apple computer!  
Open and save this as an editable pdf file. Follow the accompanying instructions.

Full Name – First Middle Last. (Example: John Eric Smith): \_\_\_\_\_

Name: Last, First MI. (Example: Smith John E.): \_\_\_\_\_

A full address is house number, street, (apt number, if applicable), city, state (two letters) and ZIP Code (no comma after state).

**Example: 123 Main ST, Apt. 45, Hometown, PA 18848**

Full Home of Record (HOR) address: \_\_\_\_\_

Cadet Specific Information SSN: \_\_\_\_\_

DD93 Date (YYYYMMDD): \_\_\_\_\_ SGLV Date Signed (MM, DD, YYYY): \_\_\_\_\_

## COMMAND / SCHOOL INFORMATION

SGLV Duty Location: \_\_\_\_\_

DD93 UIC/Unit: \_\_\_\_\_

**DD93 DATA:** If someone has died, leave phone blank and put "Deceased" in address. If you have a step-parent, email their data.  
If you have no contact with a parent, you can leave phone blank and put "Unknown" in address.

Parent One Name (Last, First MI): \_\_\_\_\_ Parent 1 Phone: \_\_\_\_\_

Parent One Full Address: \_\_\_\_\_

Parent Two Name (Last, First MI): \_\_\_\_\_ Parent 2 Phone: \_\_\_\_\_

Parent Two Full Address: \_\_\_\_\_

**BENEFICIARY(IES) FOR DEATH GRATUITY:** Person(s) who will receive any death benefits if you die (This is separate from the optional SGLV life insurance).

1ST Beneficiary Name (First then Last): \_\_\_\_\_ 1ST Beneficiary Relationship: \_\_\_\_\_

1ST Beneficiary Full Address: \_\_\_\_\_

1ST Beneficiary Phone: \_\_\_\_\_ 1ST Beneficiary Percentage: \_\_\_\_\_

2ND Beneficiary Name (First then Last): \_\_\_\_\_ 2ND Beneficiary Relationship: \_\_\_\_\_

2ND Beneficiary Full Address: \_\_\_\_\_

2ND Beneficiary Phone: \_\_\_\_\_ 2ND Beneficiary Percentage: \_\_\_\_\_

**BENEFICIARY FOR UNPAID PAY/ALLOWANCES:** The person who will receive any pay and allowances that you earned but did not receive in event of death.

Unpaid Pay Beneficiary Name / Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Unpaid Pay Beneficiary Full Address: \_\_\_\_\_ Percentage: \_\_\_\_\_

**PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD):** This is the person who will decide what happens to you and your things if you cannot.

PADD Name / Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

PADD Full Address: \_\_\_\_\_

Non-Medical Attendant: \_\_\_\_\_ (Adult who will accompany you home if injured or dead).

Geographic Location: \_\_\_\_\_ (City, State of long-term medical care/burial, often hometown)

**LIFE INSURANCE (SGLV) DATA:** Coverage only when on active duty (AD) for 28+ days. Premium is deducted from AD pay (not stipend).

Amount of Insurance Coverage: \_\_\_\_\_ (\$3.00/\$50,000 of insurance + \$1 for traumatic injury insurance/month)

For relationship, use father, mother, spouse, child, sibling. Do not split the shares between Primary and Back-up beneficiaries.

SGLV Primary Beneficiary Name: \_\_\_\_\_ SGLV Primary Relationship: \_\_\_\_\_

SGLV Primary Beneficiary Full Address: \_\_\_\_\_

SGLV Primary Beneficiary Share (percentage): \_\_\_\_\_ SGLV Primary Payout: \_\_\_\_\_

If you want more than one primary beneficiary, email the HRA the above information. The total of all primary shares must equal 100%.

SGLV Back-up Beneficiary Name: \_\_\_\_\_ SGLV Back-up Relationship: \_\_\_\_\_

SGLV Back-up Beneficiary Full Address: \_\_\_\_\_

SGLV Back-up Beneficiary Share (percentage): \_\_\_\_\_ SGLV Back-up Payout: \_\_\_\_\_

If you want more than one back-up beneficiary, email the HRA the above information. The total of all back-up shares must equal 100%.

## RECORD OF EMERGENCY DATA

OMB No. 0704-0649  
Expires 02/28/2026

The public reporting burden for this collection of information is estimated to average 15 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 the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. 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 COMPLETED FORM TO THE ABOVE ORGANIZATION.

## PRIVACY ACT STATEMENT

**AUTHORITY:** 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, and 44 USC 3101

**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.

**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 fiancé), 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. DOD IDENTIFICATION NUMBER or SSN

3a. SERVICE/CIVILIAN CATEGORY

☒ ARMY ☐ NAVY ☐ MARINE CORPS ☐ DoD ☐ CIVILIAN ☐ CONTRACTOR  
☐ AIR FORCE ☐ SPACE FORCE

b. REPORTING UNIT CODE/DUTY STATION

3c. MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

4a. SPOUSE NAME (If applicable) (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

c. PHONE NUMBERS (Home, Mobile, Other)

d. PREFERRED LANGUAGE

e. DoD AFFILIATION

5. CHILDREN

a. NAME (Last, First, Middle Initial)

b. RELATIONSHIP

c. DATE OF BIRTH  
(YYYYMMDD)

d. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER

6a. PARENT ONE NAME (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBERS (Home, Mobile, Other)

7a. PARENT TWO NAME (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBERS (Home, Mobile, Other)

8a. STEP PARENT ONE (Last, First, Middle Initial)

b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBERS (Home, Mobile, Other)

## CUI (when filled in)

9a. STEP PARENT TWO (Last, First, Middle Initial)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBERS (Home, Mobile, Other)	
10a. DO NOT NOTIFY PERSON DUE TO THEIR ILL HEALTH		b. NOTIFY INSTEAD	
11a. DESIGNATED PERSON(S) (Military: Duty Status - Whereabouts Unknown Civilian: Excused Absence-Whereabouts Unknown)		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	
12. CONTRACTING AGENCY AND TELEPHONE NUMBER (Contractors only)			
<b>SECTION 2 - BENEFITS RELATED INFORMATION</b>			
13a. BENEFICIARY(IES) FOR DEATH GRATUITY (Military only)	b. RELATIONSHIP	c. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	d. PERCENTAGE
14a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES (Military only) NAME AND RELATIONSHIP		b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER	c. PERCENTAGE
15a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) (Military only) NAME AND RELATIONSHIP	b. ADDRESS (Include ZIP Code) AND TELEPHONE NUMBER		
16. CONTINUATION/REMARKS			
17. SIGNATURE OF SERVICE MEMBER/CIVILIAN (Include rank, rate, or grade if applicable)	18. SIGNATURE OF WITNESS (Include rank, rate, or grade as appropriate)	19. DATE SIGNED (YYYYMMDD)	



# Prudential

Office of Servicemembers'  
Group Life Insurance

## Servicemembers' Group Life Insurance Election and Certificate

The SGLI Online Enrollment System (SOES) is the official system of record for Servicemembers' Group Life Insurance (SGLI) for the Uniformed Services of the United States. All coverage and beneficiary elections for members with full-time SGLI coverage should be maintained in SOES. This form should only be used in special circumstances as defined by the Uniformed Services.

### 1. About You

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Duty Location	Branch of Service	Current Amount of SGLI
<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="text"/>	<input type="text"/>
If married, spouse's name		Spouse's Date of Birth

### 2. About Your Coverage *This form replaces all prior designations.*

**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.*  
*(Increasing SGLI does not automatically increase FSGLI, if FSGLI was < \$100,000.)*
- ☐ Reduce my SGLI coverage to \$ \_\_\_\_\_. *You must complete sections 3 & 5.*
- ☐ Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." *You must complete section 5 only.*  
" \_\_\_\_\_ "

SGLI coverage is available in increments of \$50,000 up to a maximum of \$500,000. Traumatic Injury Protection (TSGLI) coverage is automatic with SGLI coverage.

### 3. About Your Beneficiaries *Please always complete this section unless you are declining coverage. If you do not specifically name beneficiaries, your insurance will be paid by law. Please read the information on page 3 before selecting your beneficiaries.*

Primary Name and Address	Social Security Number (If available)	Relationship to you	Share to each (%) – The sum of shares must equal 100%. <b>Each share must be greater than 0%.</b>	Payment Option (Lump sum* or 36 equal monthly payments)
1.	<input type="text"/>			
2.	<input type="text"/>			
3.	<input type="text"/>			
4.	<input type="text"/>			

**Secondary  
Name and Address**

**Social Security Number**  
(If available)

**Relationship  
to you**

**Share to each (%) – The  
sum of shares must equal  
100%. *Each share must  
be greater than 0%.*** **Payment Option**  
(Lump sum\* or  
36 equal monthly  
payments)

1.

2.

3.

4.

☐ **Have more beneficiaries?** Check this box if 1) You have additional beneficiaries and are completing the Supplemental SGLI Beneficiary Form, SGLV 8286S or, 2) You are attaching additional documentation to complete your beneficiary designation noted above.

\*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.

The Bank of New York Mellon is the Administrator 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. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

**4. About Your Health** Complete this section *ONLY* if you are restoring or increasing coverage.

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender ☐ Female  
☐ Male

**Have you had, been treated for, or had known indications of:**

- a. A heart condition?
- b. High blood pressure?
- c. A neurological disorder?
- d. Diabetes?
- e. Cancer or tumors?
- f. Have you ever been diagnosed as having a disease of the immune system?
- g. Do you have any known physical impairments, deformities, or ill health not covered above?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<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. Please attach additional documentation if necessary.**

If you answered "yes" to any question above, a request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI). If you answered "no" to all the questions above, your request for increased coverage takes effect immediately.

## 5. Your Signature *You must complete this section.*

### I have read the information on page 3 and instructions on page 4 and understand that:

- This form replaces any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) at the same time, but the combined amount cannot be more than \$500,000. VGLI is renewable post-separation coverage available to Service Members who separate with SGLI coverage.
- Reducing SGLI coverage can affect the amount of my family coverage (FSGLI) and VGLI coverage (see instructions on page 4).
- By declining or canceling SGLI coverage, I am also declining family coverage (FSGLI) and Traumatic Injury Protection (TSGLI). I am also not eligible for any post-separation coverage (see instructions on page 4).

### Please take note:

If my spouse is...	and...	then...
also a member of the uniform services	we married on or after January 2, 2013	spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 8286A.
not a member of the uniformed services	I am married, or get married after completing this form, and have not declined SGLI,	spouse 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 do so will result in a debt for unpaid premiums. I can decline spouse coverage by completing SGLV 8286A.

- I am free to name anyone I want as my beneficiary. I understand if I am married and have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that my spouse may be notified that he/she (or my child) is not my designated beneficiary.

I certify that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits. If declining or reducing SGLI coverage, I have received the appropriate general information concerning life insurance from my Unit Personnel Clerk.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Member Signature	Social Security Number	Date Signed (MM, DD, YYYY)

<input type="text"/>
Address

**Submit this form to your Unit Personnel Clerk. By completing this section the Unit Personnel Clerk acknowledges that they have counseled the Service Member in regards to the information provided on page 4 of this form.**

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	