SURVIVOR BENEFIT PLAN (SBP)
AND RESERVE COMPONENT SURVIVOR BENEFIT PLAN (RCSBP)
OPEN SEASON **ELECTION TO DISCONTINUE PARTICIPATION**

(Public Law 117-263) (December 23, 2022 – January 1, 2024)
(Please read Privacy Act Statement and Instructions before completing form.)

ADVANTAGES AND DISADVANTAGES OF CONTINUED SBP/RCSBP PARTICIPATION

ADVANTAGES OF CONTINUED SBP/RCSBP PARTICIPATION

Peace of Mind. Retired pay stops at your death. SBP/RCSBP gives you the assurance of potentially continuing a portion of your retired pay to your spouse (including former spouse), child(ren) or insurable interest beneficiary for life.

Tax Advantages. SBP/RCSBP premiums withheld from retired pay are not taxed. For example, if your monthly retired pay is $2,000, your SBP costs of $130 are not taxed, thus your real SBP cost (assuming a 28 percent marginal tax bracket) is $93.60. Also, it may be wise financial strategy to receive SBP's tax advantage when the retiree is in a higher marginal tax bracket, rather than when the survivor may be in a lower one.

Government Subsidy. The government pays for a portion of the SBP/RCSBP costs. Your premiums pay for only part of your SBP/RCSBP benefit and the government subsidizes the remainder.

Inflation Protected Benefits. SBP/RCSBP benefits are inflation-protected due to cost-of-living adjustments (COLA). Over the years of retirement, inflation can result in substantial changes in the value of annuity payments.

Amount of Risk. In most cases, SBP/RCSBP premiums will be recouped as benefits within three years after the retiree's death. You must weigh the higher risk of leaving your survivor with insufficient income without a SBP/RCSBP annuity against the smaller risk that your survivor might not get back every cent paid for coverage. A spouse may receive SBP/RCSBP payments for many years, receiving several times the amount paid in premiums.

Resumed Coverage. Even if your covered spouse or former spouse dies first, you may resume coverage for a subsequent spouse without any penalty based on advanced age, deteriorated health, or other risk factors.

DISADVANTAGES OF CONTINUED SBP PARTICIPATION

Permanence. There may not be another opportunity to discontinue beyond this special one-year period (i.e., if you no longer wish to provide a benefit to your beneficiary, this could be your only chance to discontinue your participation).

Return of Costs. Your beneficiary might not recover total payments made into the plan (e.g., if you are a retiree with a much older spouse; if you are certain you will never remarry).

Reduced Need. You may no longer need the coverage SBP provides (e.g., if you no longer need to protect your retired pay).

Taxable Annuity. The SBP annuity is taxable as income when received by the beneficiary.

IMPORTANT REMINDERS

Barred Forever. Elections to discontinue participation may not be cancelled. Once you discontinue participation, you cannot reenter the Plan (absent very unusual circumstances). RCSBP participants who discontinue will not be eligible to reenter the Plan upon reaching eligibility age for retired pay.

No Premium Refund. You received protection for the period you were enrolled in the Plan. Therefore, no premiums will be refunded for the periods in which you had coverage. Your past costs are generally immaterial to this decision; you should make your decision based on future benefits and costs. If you are in arrears on payment of premiums for coverage already received, discontinuing future participation does not release you from liability for those unpaid premiums. For RCSBP coverage already received, you will still be charged the premiums owed for that coverage at eligibility age.

I confirm that I have read, understand and agree to the above _____ Initial Here

Name _____ **SSN** _____

SURVIVOR BENEFIT PLAN (SBP)
AND RESERVE COMPONENT SURVIVOR BENEFIT PLAN (RCSBP)
OPEN SEASON **ELECTION TO DISCONTINUE PARTICIPATION**

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 117-263 of the National Defense Authorization Act of 2023.

PRINCIPAL PURPOSE(S): Used by an SBP or RCSBP participant to discontinue participation in SBP/RCSBP during the open season period December 23, 2022 through January 1, 2024

ROUTINE USE{S): To discontinue participation in SBP or RCSBP under the provisions of Public Law 117-263. To provide for evidence of beneficiary concurrence in the member's election to discontinue. Upon approval of the discontinuance in participation of SBP, deductions from retired pay will be discontinued. For RCSBP coverage already received, member's will still be charged the premiums owed for that coverage, for the period enrolled, at eligibility age..

DISCLOSURE: Voluntary; however, failure to provide requested information may delay the termination process and may result in the expiration of the period of eligibility to discontinue.

SECTION I. INSTRUCTIONS

GENERAL.

1. Applicability: This form is used to voluntarily discontinue participation in the Survivor Benefit Plan (SBP)/Reserve Component Survivor Benefit Plan (RCSBP) as permitted by Public Law 117-263.

1. Read these instructions and the Advantages and Disadvantages of Continued SBP/RCSBP Participation carefully before completing this form. Type or print legibly. Maintain a copy of this form with your records.

3. Submit the completed form to the appropriate finance center listed below. It is recommended to use certified mail for proof of date of mailing and receipt. For discontinuance in **SBP**:

Army, Air Force, Navy, Marine Corps or Space Force retirees should submit to the Defense Finance and Accounting Service (DFAS)
To use the convenient askDFAS online upload tool visit the webpage https://www.dfas.mil/sbpopenseason23 for instruction on submitting via dfas.mil.

DFAS Retired Pay Fax: 1 800-469-6559

Mail: Defense Finance and Accounting Service U.S. Military Retired Pay, 8899 E. 56th Street, Indianapolis, IN 46249-1200.

U.S. Coast Guard, National Oceanic and Atmospheric Administration (NOAA), and U.S. Public Health Service (USPHS) retirees should submit to: Mail: Retiree and Annuitant Services Branch Chief, USCG Pay and Personnel Center, 444 S.E. Quincy Street, Topeka, KS, 66683-3591 or via email to ppc-dg-customercare@uscg.mil

For discontinuance in **RCSBP**:

Army Reserve/Army National Guard:
Mail: ATTN: RPMD-ROR-GAR, Human Resources Command, 1600 Spearhead Division Avenue Dept.482, Ft. Knox, KY 40122-5402
or via email to usarmy.knox.hrc.mbx.rpmd-ord-sbp-regulatory-and-policy-team@army.mil

Air Force Reserve/Air National Guard
Mail: HQ ARPC/DPTTB, 18420 E. Silvercreek Ave, Bldg 390 MS68, Buckley AFB, CO 80011 or via myFFS

Navy Reserve
Mail: Navy Personnel Command (PERS-912), 5720 Integrity Drive, Millington, TN, 38055-9120

Marine Corps Reserve:
Mail: Headquarters U. S. Marine Corps, Manpower and Reserve Affairs (MMSR-5), 3280 Russell Road, Quantico, VA, 22134- 5103
or via email to smb.manpower.mmsr5@usmc.mil

U.S. Coast Guard:
Mail: Separations Branch Chief, USCG Pay and Personnel Center, 444 S.E. Quincy Street, Topeka, KS, 66683-3591 or
via email to ppc-dg-customercare@uscg.mil

SECTION II – RETIREE or RESERVIST (Awaiting Pay) IDENTIFICATION
Items 1 through 3 - Self-explanatory.
Item 4 - Mark the plan in which you have coverage.
Item 5 - If you marked SBP in Item 4, enter your retirement date in Item 5.
Item 6 - If you marked RCSBP in Item 4, enter your Notice of Eligibility (NOE) date in Item
6. Item 7-9 - Self-explanatory

SECTION III – CURRENT COVERAGE. Mark the type of current coverage you request to discontinue

SECTION IV – REQUEST TO DISCONTINUE. Read the statement carefully, then sign your name and indicate the date of your signature.

SECTION V- CERTIFICATION. SBP Counselor or Notary is required to witness the member's signature and date of completion of this form.

SECTION VI - SPOUSE CONCURRENCE. If you are participating in SBP/RCSBP and are currently married, concurrence of your spouse is required to discontinue any coverage.

SECTION VII- CERTIFICATION FOR SPOUSE CONCURRENCE. An SBP Counselor or Notary is required to witness the current spouse's signature and date of completion of this form.

SECTION VIII-CHILD CONCURRENCE. In some circumstances, discontinuing coverage for a child (who is of legal age) will also require the concurrence of the child. If the child is not disabled and is between the age 18 and 22, discontinuing existing child, spouse and child or former spouse and child coverage will require the child to concur. Coverage for a minor child or disabled child does not require child concurrence BUT, such coverage should not be discontinued without a full understanding of the consequences. If there is more than one child that needs to provide concurrence, please duplicate and complete the
child concurrence/certification page, as many times as needed and submit with the full packet.

SECTION IX-CERTIFICATION FOR CHILD CONCURRENCE. An SBP Counselor or Notary is required to witness the child's signature and date of completion of this form. This applies to children of legal age (between age 18 and 22) who are not disabled.

SECTION X-FORMER SPOUSE CONCURRENCE. If election is to discontinue former spouse or former spouse and child coverage, the former spouse's concurrence is required. If the former spouse election was made pursuant to a court order, the court order must be amended to allow for the discontinuance.

SECTION XI-CERTIFICATION FOR FORMER SPOUSE CONCURRENCE. An SBP Counselor or Notary is required to witness the former spouse's signature and date of completion of this form. If the former spouse election was made pursuant to a court order, the court order must be amended to allow for the discontinuance.

SECTION XII-NATURAL INTEREST PERSON CONCURRENCE. If election is to discontinue NIP coverage, the NIP's concurrence is required (if legally capable). The discontinuation of NIP coverage under Public Law 117-263 of December 23, 2022 (the law establishing the open season) requires the concurrence of the member's spouse (if one exists) and the concurrence of the NIP beneficiary. Discontinuation of NIP coverage under 10 U.S.C.§ 1448(b) does not require
such concurrence. For information on discontinuing NIP coverage under 10 U.S.C § 1448(b), you may contact the appropriate agency in paragraph 3 of Section 1 of these instructions or see Department of Defense Financial Management Regulations (DODFMR) Volume 7B (Retired Pay) Chapter 43, paragraph 7.0, which is publicly available.

SECTION XIII-CERTIFICATION FOR NATURAL INTEREST CONCURRENCE. An SBP Counselor or Notary is required to witness the NIP's signature and date of completion of this form.

SECTION II. RETIREE or RESERVIST (Awaiting Pay) IDENTIFICATION

1. **NAME** *(Last, First, Middle Initial)*	2. **SSN**	3. **DATE OF BIRTH** *(YYYYMMDD)*
4. **TYPE OF EXISTING COVERAGE** (Mark One) ☐ SBP (COMPLETE 5.) ☐ RCSBP (COMPLETE 6.)	5. **RETIREMENT DATE** (YYYYMMDD).	6. **NOTICE OF ELIGIBILITY DATE** (if awaiting non-regular retired pay at eligibility age) (YYYYMMDD)

7. **MAILING ADDRESS** *(Street, Apartment Number, City, State, and ZIP Code)*	8. **TELEPHONE NUMBER** *(Include area code)*	9. **EMAIL ADDRESS** (Optional)

SECTION III. CURRENT COVERAGE (X one)

	SPOUSE		SPOUSE AND CHILD		CHILD
	INSURABLE INTEREST		FORMER SPOUSE		FORMER SPOUSE AND CHILD

SECTION IV. REQUEST TO DISCONTINUE

RETIREE: By my signature, I hereby **VOLUNTARILY** request to discontinue participation in SBP (or RCSBP, if applicable). I have read and understand the disadvantages and advantages of this decision, as listed on the first page of this form. I understand that SBP/RCSBP coverage will discontinue on the first day of the month following the month that this request is received by the Defense Finance and Accounting Service or the appropriate Reserve Component Personnel Center, as applicable. I understand that no refund of costs already paid for SBP coverage will be made and if discontinuing RCSBP coverage, I will be responsible to pay the premiums for coverage already received, and that SBP/RCSBP benefits will not be paid upon my death. I further understand that once I discontinue SBP or RCSBP coverage, I cannot reenter the Plan.

a. MEMBER'S NAME	b. MEMBER'S SIGNATURE	c. DATE SIGNED (YYYYMMDD)

SECTION V. CERTIFICATION (SBP Counselor or Notary Public)

WITNESS: By my signature, I certify that the member named above signed this form in my presence and that the above named member produced a photo bearing identification document, which identified him/her as the person signing this request to discontinue SBP or RCSBP coverage.

The member's signature must be either (a) notarized, or (b) witnessed by an SBP counselor.

a. (If the member's signature is notarized):

State of _____
County of _____

By my signature, I certify that on this _____ day of _____, 202___,
the above named member appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the member.

Signature of notarial officer:

Title of office:

My commission expires:

Notary Seal

OR

b. (If the member's signature is witnessed by an SBP counselor):

SBP Counselor: By my signature, I certify that on this _____ day of _____, 202___,
the above named member appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the member.

SBP Counselor Name (Print)	SBP Counselor Signature	Date Signed (YYYYMMDD)
SBP Counselor Unit Name	SBP Counselor Address	SBP Counselor e-mail and phone

RETIREE OR RESERVIST (Awaiting Pay) NAME (Last, First, Middle Initial)	SSN

SECTION VI. SPOUSE CONCURRENCE

SPOUSE: By my signature, I certify that I am the legal spouse of the above listed retiree. I have read and understand the disadvantages and advantages of this decision, as listed on the front of this form. I understand that I will receive no SBP or RCSBP benefits upon the death of my spouse. I concur with the decision to discontinue participation in SBP or RCSBP and have signed this statement voluntarily and of my own free will. I further understand that once my spouse discontinues participation in SBP or RCSBP, he/she cannot reenter the Plan.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. PRINTED NAME *(Last, First, Middle Initial)*	d. SSN

SECTION VII. CERTIFICATION *(SBP Counselor or Notary Public)*

WITNESS: By my signature, I certify that the above named spouse signed this form in my presence and that the above named spouse produced a photo bearing identification document, which identified him/her as the person signing this request to discontinue SBP or RCSBP coverage.

The spouse's signature must be either (a) notarized, or (b) witnessed by an SBP counselor.

a. (If the spouse's signature is notarized):

State of _____
County of _____

By my signature, I certify that on this _____ day of _____, 202___,
the above named spouse appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the spouse.

Signature of notarial officer:

Title of office:

My commission expires:

Notary Seal

OR

b. (If the spouse's signature is witnessed by an SBP counselor):

SBP Counselor: By my signature, I certify that on this _____ day of _____, 202___,
the above named spouse appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the spouse.

SBP Counselor Name (Print)	SBP Counselor Signature	Date Signed (YYYYMMDD)
SBP Counselor Unit Name	**SBP Counselor Address**	**SBP Counselor e-mail and phone**

RETIREE OR RESERVIST (Awaiting Pay) NAME (Last, First, Middle Initial)	SSN

SECTION VIII. CHILD CONCURRENCE

CHILD: By my signature, I certify that I am the child, between the ages 18-22, of the above listed retiree. I have read and understand the disadvantages and advantages of this decision, as listed on the first page of this form. I understand that I will receive no SBP or RCSBP benefits upon the death of my parent/sponsor. I concur with the decision to discontinue participation in SBP or RCSBP and have signed this statement voluntarily and of my own free will. I further understand that once my parent/sponsor discontinues participation in SBP or RCSBP, he/she cannot reenter the Plan. (Applicable to children of legal age and not disabled. (See instructions.) Note: If there is more than one child that needs to provide concurrence, please duplicate and complete the child concurrence/certification page, as many times as needed and submit with the full packet.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. PRINTED NAME *(Last, First, Middle Initial)*	d. SSN

SECTION IX. CERTIFICATION *(SBP Counselor or Notary Public)*

WITNESS: By my signature, I certify that the above named child signed this form in my presence and that the above named child produced a photo bearing identification document, which identified him/her as the person signing this request to discontinue SBP or RCSBP coverage.

The child's signature must be either (a) notarized, or (b) witnessed by an SBP counselor.

a. (If the child's signature is notarized):

State of _____
County of _____

By my signature, I certify that on this _____ day of _____, 202___,
the above named child appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the child.

Signature of notarial officer:

Title of office:

My commission expires:

Notary Seal

OR

b. (If the child's signature is witnessed by an SBP counselor):

SBP Counselor: By my signature, I certify that on this _____ day of _____, 202___,
the above named child appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the child.

SBP Counselor Name (Print)	SBP Counselor Signature	Date Signed (YYYYMMDD)
SBP Counselor Unit Name	SBP Counselor Address	SBP Counselor e-mail and phone

RETIREE OR RESERVIST (Awaiting Pay) NAME (Last, First, Middle Initial)	SSN

SECTION X. FORMER SPOUSE CONCURRENCE

FORMER SPOUSE: By my signature, I certify that I am the former spouse of the above listed retiree. I have read and understand the disadvantages and advantages of this decision, as listed on the first page of this form. I understand that I will receive no SBP benefits upon the death of my former spouse. I concur with the decision to terminate participation in SBP and have signed this statement voluntarily and of my own free will. I further understand that once my former spouse discontinues participation in SBP, he/she cannot reenter the Plan.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. PRINTED NAME *(Last, First, Middle Initial)*	d. SSN

SECTION XI. CERTIFICATION *(SBP Counselor or Notary Public)*

WITNESS: By my signature, I certify that the above named former spouse signed this form in my presence and that the above named former spouse produced a photo bearing identification document, which identified him/her as the person signing this request to discontinue SBP or RCSBP coverage.

The former spouse's signature must be either (a) notarized, or (b) witnessed by an SBP counselor.

a. (If the former spouse's signature is notarized):

State of _____
County of _____

By my signature, I certify that on this _____ day of _____, 202___,
the above named former spouse appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the former spouse.

Signature of notarial officer:

Title of office:

My commission expires:

Notary Seal

OR

b. (If the former spouse's signature is witnessed by an SBP counselor):

SBP Counselor: By my signature, I certify that on this _____ day of _____, 202___,
the above named former spouse appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the former spouse.

SBP Counselor Name (Print)	SBP Counselor Signature	Date Signed (YYYYMMDD)
SBP Counselor Unit Name	SBP Counselor Address	SBP Counselor e-mail and phone

RETIREE OR RESERVIST (Awaiting Pay) NAME (Last, First, Middle Initial)	SSN

SECTION XII. NATURAL INTEREST PERSON (NIP) CONCURRENCE

NATURAL INTEREST PERSON: By my signature, I certify that I am the NIP of the above listed retiree. I have read and understand the disadvantages and advantages of this decision, as listed on the first page of this form. I understand that I will receive no SBP or RCSBP benefits upon the death of the retiree. I concur with the decision to discontinue participation in SBP or RCSBP and have signed this statement voluntarily and of my own free will. I further understand that once the retiree discontinues participation in SBP or RCSBP, he/she cannot reenter the Plan. Please note that concurrence of the NIP is only required if the member is discontinuing NIP coverage based on Public Law 117-263. See instruction for Section XVI for further information on discontinuing NIP coverage under 10 U.S.C. § 1448 (b).

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. PRINTED NAME *(Last, First, Middle Initial)*	d. SSN

SECTION XIII. CERTIFICATION *(SBP Counselor or Notary Public)*

WITNESS: By my signature, I certify that the above named NIP signed this form in my presence and that the above named NIP produced a photo bearing identification document, which identified him/her as the person signing this request to discontinue SBP or RCSBP coverage.

The insurable interest person's signature must be either (a) notarized, or (b) witnessed by an SBP counselor.

a. (If the NIP beneficiary's signature is notarized):

State of _____
County of _____

By my signature, I certify that on this _____ day of _____, 202___,
the above named NIP beneficiary appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the NIP beneficiary.

Signature of notarial officer:

Title of office:

My commission expires:

Notary Seal

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b. (If the NIP beneficiary's signature is witnessed by an SBP counselor):

SBP Counselor: By my signature, I certify that on this _____ day of _____, 202___,
the above named NIP beneficiary appeared before me, produced satisfactory evidence of identity and signed this form in my presence. The signature on the above statement is verified as the signature of the NIP beneficiary.

SBP Counselor Name (Print)	SBP Counselor Signature	Date Signed (YYYYMMDD)
SBP Counselor Unit Name	SBP Counselor Address	SBP Counselor e-mail and phone