PHS-5150 (Page 1)
(Rev. 7/07)

Department of Health and Human Services
Commissioned Corps of the U.S. Public Health Service

SURVIVOR BENEFIT PLAN (SBP) ELECTION CERTIFICATE

This form MUST be completed and submitted whether or not you choose to participate in SBP.

NAME *(Last, First, Middle)*	SSAN	GRADE	DATE OF BIRTH	DATE OF RETIREMENT

1. a. Are you married? ☐ Yes ☐ No If yes, your spouse *must* complete section 5 or this election form will be invalid, and you will be enrolled for the full amount.
   b. Do you have dependent children? ☐ Yes ☐ No
   c. Do you have a former spouse? ☐ Yes ☐ No
   d. Do you want your survivors to receive an annuity under the SBP? ☐ Yes ☐ No
   NOTE: If the answer to item 1.d is "No", complete item 4 and, if applicable, item 5.

2. a. Type Coverage Desired: *(check one)*
   (1) ☐ Spouse Only
   (2) ☐ Spouse and Child(ren)
   (3) ☐ Child(ren) Only
   (4) ☐ Former Spouse
   (5) ☐ Former Spouse and Child(ren)
   (6) ☐ Person Having an Insurable Interest

   b. Amount of retired pay to be used when calculating SBP
   Annuity: $ _____

   NOTE: The survivor annuity will be 55% (50% if the spouse beneficiary is age 62 or older when the annuity starts) of whatever portion of your retired pay you specify above. You may specify any amount between a minimum of $300 (which increases each year by the same amount as increases in retired pay) and a maximum of your full retired pay. You may write either minimum or maximum in the space above, and we will compute the figure, or you may designate a dollar amount. If you elect SBP for an Insurable Interest Person, you are required by law to use your full retired pay. As of April 1, 2008, the offset required at age 62 will stop. The survivor annuity will be based on 55% for life.

3. a. DESIGNATION OF SPOUSE AND CHILD(REN)

SPOUSE'S NAME *(First, Middle, Last)*	SSAN	DATE OF BIRTH
DATE OF MARRIAGE	**PLACE OF MARRIAGE**	

List only unmarried child(ren): (1) under age 22; (2) over age 22 and incapable of self-support because of a disability incurred before age 18; or (3) after age 18 but before age 22 while attending school full time. *(Documentation must be supplied attesting to a child's disability)* - Use additional sheet if necessary.

b. Child's Name *(First, Middle, Last)*	Date of Birth *(Mo.) (Day) (Yr.)*	Child's Name *(First, Middle, Last)*	Date of Birth *(Mo.) (Day) (Yr.)*

c. DESIGNATION OF FORMER SPOUSE OR INSURABLE INTEREST BENEFICIARY

NAME OF PERSON *(First, Middle, Last)*	SSAN	DATE OF BIRTH
ADDRESS *(Include Zip Code)*	RELATIONSHIP *(If former spouse, attach a copy of divorce decree)*	

NOTE: Please complete Section b. if you also want to provide coverage for children along with former spouse.

4. CHECK ONE:
   ☐ I certify that there is no divorce or separation decree in effect that orders me to participate in the Survivor Benefit Plan on behalf of my former spouse.
   ☐ I certify that I have requested participation in the Survivor Benefit Plan on behalf of my former spouse in accordance with the court order or voluntary agreement which I have attached to this election certificate.

   I make this election voluntarily and fully understand that my election is irrevocable, except as provided on the reverse side of this form.

   _____ _____
   (Signature of Retiree) *(Date)*

   I certify that I am well acquainted with the above, _____, and that the signature of the officer was affixed in my presence.
   (Retiree's Name)

   _____ _____ _____
   (Signature of Witness) *(Address of Witness)* *(City, State, Zip)*

5. TO BE COMPLETED BY THE OFFICER'S SPOUSE:

   I have read the information that was supplied to my spouse describing the Survivor Benefit Plan, which permits a retiree to have deductions made from his/her retired pay so that upon his/her death, an annuity will be paid by the Department of Health and Human Services to the beneficiary designated on this form. I understand that if my spouse is not required by a court order or other agreement to elect a former spouse as his/her beneficiary, that he/she cannot elect less than maximum SBP coverage for me and our children (if any) unless I agree with that decision and show my agreement by completing the appropriate sections of the form below. If I do not agree with his/her election of less than the maximum coverage or if I do not sign this form below, it will result in my spouse's enrollment in SBP at the maximum level possible and I will be named as his/her beneficiary automatically. I understand that my spouse's decision is to:

   ☐ Elect less than the maximum survivor annuity benefit
   ☐ Elect coverage for a former spouse
   ☐ Elect coverage for child(ren) only
   ☐ Elect maximum coverage *(spouse and children)*
   ☐ Elect maximum coverage *(spouse only)*
   ☐ Not participate in the plan

   I hereby certify that I _____ with my spouse's SBP election as shown on this form.
   (fill in either agree or disagree)

   _____ _____
   (Signature of Retiree's Spouse) *(Date)*

   I certify that I am well acquainted with the above, _____, and that the signature was affixed in my presence.
   (Spouse's Name)

   _____ _____ _____
   (Signature of Witness) *(Address of Witness)* *(City, State, Zip)*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Commissioned Corps of the U.S. Public Health Service

INFORMATION AND INSTRUCTIONS

FOR FORM PHS-5150, "SURVIVOR BENEFIT PLAN (SBP) ELECTION CERTIFICATE"

1. Your election must be received by the Compensation Branch, or postmarked before the effective date of your retirement or you will be enrolled in SBP at the maximum level.

   Please note that the postmark date is not always clearly stamped on the envelope. It is suggested, therefore, that you submit your election by registered or certified mail, return receipt requested. This will provide evidence that the election was placed in the mail service before the effective date of your retirement. It will also provide you with evidence that the election was received, although the Compensation Branch will acknowledge receipt by returning a photocopy of the form to you.

2. SUBMITTAL OF COMPLETED FORM. This form should be completed *whether or not* you want the coverage. Keep a photocopy for your records.

   The form must be dated, signed, witnessed, and filed with the:

   Office of the Commissioned Corps Support Services/PSC
   ATTN: Compensation Branch
   5600 Fishers Lane, Room 4-50
   Rockville, MD 20857-0001

3. ELECTIONS IRREVOCABLE. If you elect not to participate in SBP at this time, and you have an eligible spouse or child, you will be barred from enrolling in SBP at some later date to provide coverage to one of these same individuals, and any other spouse or child you acquire in the future. Once you elect a beneficiary under the SBP, you cannot voluntarily change the election unless certain specific events occur. If you elected spouse coverage, it will be suspended *only* upon the death of your spouse or upon dissolution of your marriage. In the event of divorce, spouse coverage can be converted to former spouse coverage. If you elected coverage for your children, coverage will continue until your youngest child is no longer an eligible beneficiary. If you elected coverage of an insurable interest person because you were unmarried, you can change that election to spouse and/or child coverage only if you acquire a spouse and/or child after retirement. An election to cover a former spouse can only be changed if you were unmarried at the time of retirement, acquire a spouse and/or child subsequent to retirement, and the court order or voluntary agreement related to the initial election is modified to permit the change. For more information about SBP, please see Pamphlet No. 24, 'Information on Commissioned Officers Retirement," at *http://dcp.psc.gov/DCP_pubs.asp* ; Commissioned Corps Instruction 661.04, "Survivor Benefit Plan," at *http://dcp.psc.gov/eccis/documents/CCPM29_5_5.PDF* ; or phone the Compensation Branch at 1-800-638-8744 or 301-594-2963.

4. MONTHLY COST

   a. SPOUSE/FORMER SPOUSE ONLY. If the amount of the designated retired pay (front of form, Section 2.b.) that you elected is greater than $1,000, your monthly cost will be 6.5 percent of the amount elected. If the amount is less than $1,000, the cost of coverage is 2.5 percent of the first $300 (indexed by the latest active-duty cost of living increase) plus 10 percent of the remaining amount.

   b. SPOUSE/FORMER SPOUSE AND CHILD(REN). The cost of coverage is the same for Spouse Only, plus an additional charge for children that will depend on your age, your spouse's age, and the age of your youngest child. The additional charge should average about one-half of one percent of the amount of your designated base amount. The additional cost for children will cease when all children become ineligible.

   c. CHILD(REN) ONLY. The cost of coverage will depend on your age and the age of your youngest child but should average about 3 percent of your designated base amount. The additional cost for children will cease when all children become ineligible.

   d. PERSON WITH INSURABLE INTEREST. Cost of coverage is 10 percent of full retired pay, plus 5 percent of full retired pay for each full 5 years that your age exceeds that of the person named. The total cost will not exceed 40 percent of your gross retired pay. The cost will terminate if the person named dies before you, and you may not name another person as an insurable interest replacement. You may change the annuity coverage at any time if you marry or acquire a dependent child. If the person named as insurable interest is further removed than a cousin, evidence will be required to substantiate that person's insurable interest in you.

PRIVACY ACT NOTIFICATION STATEMENT FOR FORM PHS-5150, "SURVIVOR BENEFIT PLAN (SBP) ELECTION CERTIFICATE"

The information provided on this form will become part of record systems 09-40-0001, "PHS Commissioned Corps General Personnel Records, HHS/PSC/HRS;" and 09-40-0010, "Pay, Leave, and Attendance Records, HHS/PSC/HRS." Our authority to collect this information is 10 U.S.C. 1447 et seq; 42 U.S.C. 213a; and 42 U.S.C. 202.

The information you provide on this form will be used to enroll you and your designated beneficiaries in SBP, or to document your decision not to participate in SBP. The information provided will be released to your current spouse if the spouse has not signed the reverse of this form. This notification is required by law. Information on this form may be released in response to interrogatories submitted to the Department pursuant to an action for divorce, in the event of your death if necessary to facilitate settlement of your estate, or to other Federal agencies to help adjudicate claims for other Federal benefits. With the exception of those routine uses authorized for records contained in the system notices cited above, this information will not be released for any other reason without your express written consent.

The disclosure of this information is required to ensure that your preferences are carried out. If you fail to submit this form prior to your retirement, you will be enrolled in SBP at the maximum level in accordance with the SBP law.