

## Declaration for Federal Employment\*

(\*This form may also be used to assess fitness for federal contract employment)

### GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

2. **SOCIAL SECURITY NUMBER**

3a. **PLACE OF BIRTH** (Include city and state or country)

3b. **ARE YOU A U.S. CITIZEN?**

YES  NO (If "NO", provide country of citizenship)

4. **DATE OF BIRTH** (MM / DD / YYYY)

5. **OTHER NAMES EVER USED** (For example, maiden name, nickname, etc)

6. **PHONE NUMBERS** (Include area codes)

Day

Night

### Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959?

YES  NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System?

YES (If "YES", proceed to 8.)  NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in item 16.

### Military Service

8. Have you ever served in the United States military?

YES (If "YES", provide information below)  NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.

If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

### Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.

YES  NO

10. Have you been convicted by a military court-martial in the past 7 years? (If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.

YES  NO

11. Are you currently under charges for any violation of law? If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.

YES  NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.

YES  NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.

YES  NO

# Declaration for Federal Employment\*

(\*This form may also be used to assess fitness for federal contract employment)

## Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.

YES  NO

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service?

YES  NO

## Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position and your agency is authorized to ask them).

## Certifications / Additional Questions

**APPLICANT:** If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

**APPOINTEE:** If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. I certify that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. I consent to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. I understand that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Sign in ink)

17b. Appointee's Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Sign in ink)

**Appointing Officer:**  
Enter Date of Appointment or Conversion  
MM / DD / YYYY

18. Appointee (Only respond if you have been employed by the Federal Government before): Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? \_\_\_\_\_ DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance?  YES  NO  DO NOT KNOW

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled.  YES  NO  DO NOT KNOW

Requires

Everyone

STATEMENT OF PRIOR FEDERAL SERVICE

To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)
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4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?  
 Yes — If "Yes", check this block and skip to Item 8.  No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?

Yes — If "Yes", list the following information.  No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	
Prior service time, basic training, first AIT/tech school, deployment.							

8. Do you claim any type of veterans' preference which has not been verified?

No  Yes — Check one of the statements, if it applies to you. I claim preference as the:  
 Spouse of a disabled veteran  Mother of a deceased or disabled veteran  Unmarried widow/widower of a veteran

9. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date
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# Everyone

## TRS AND FEHB ACKNOWLEDGMENT FORM

(Revised 15 December 2014)

The John Warner National Defense Authorization Act for 2007 (P.L. 109-364), signed by President George W. Bush on 17 October 2006, excludes individuals eligible for health insurance under the Federal Employees Health Benefits (FEHB) Program from coverage under TRICARE Reserve Select (TRS).

The following chart reflects eligibility to enroll or continue coverage under TRS:

	Eligible for FEHB	Enrolled In FEHB	Eligible for FEHB through a family member	Enrolled in FEHB through a family member	Enroll In TRS?
Selected Reserve Member	No	No	N/A	N/A	Yes
Selected Reserve Member	Yes	No	N/A	N/A	No (if eligible for FEHB, cannot enroll in TRS)
Selected Reserve Member	Yes	Yes	N/A	N/A	No (if eligible for or enrolled in FEHB, cannot enroll in TRS)
Selected Reserve Member	No	No	Yes	No	Yes (however cannot enroll in both FEHB and TRS)
Selected Reserve Member	No	No	Yes	Yes	No (if enrolled in FEHB, cannot enroll in TRS)
Family Member	Yes	No	N/A	N/A	Yes (however cannot enroll in both FEHB and TRS)
Family Member	Yes	Yes	N/A	N/A	No (if enrolled in FEHB, cannot enroll in TRS)

You were recently hired as a permanent or indefinite federal employee. This makes you *eligible* to enroll in the FEHB program. Upon *eligibility* for FEHB, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

If you are a temporary employee, you will be *eligible* to enroll in the FEHB when the temporary appointment is expected to be for 90 consecutive days or more. If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If the appointment is extended without a break in service to 90 consecutive days or more, you will be notified, and information regarding your FEHB eligibility will be provided to you. Upon *eligibility*, whether or not you elect to enroll in the FEHB program, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

If you have any questions about how to terminate your TRS enrollment, contact UnitedHealthcare Military & Veterans Customer Service at the phone number above or their web site at [www.uhcmilitarywest.com](http://www.uhcmilitarywest.com).

If you fail to end your TRS coverage as required, TRICARE will terminate your coverage retroactive to when you became eligible for FEHB and you will be responsible for any health care costs after the effective date of termination. You could also face a fine and/or a charge of fraud.

Please sign and date this letter to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PRINTED NAME)

# Temp & Perm



## Employment Eligibility Verification Department of Homeland Security U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

### Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ]		Employee's E-mail Address			Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>
<i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>
1. Alien Registration Number/USCIS Number: _____ <b>OR</b>
2. Form I-94 Admission Number: _____ <b>OR</b>
3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
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### Preparer and/or Translator Certification (check one):

<input type="checkbox"/> I did not use a preparer or translator.	<input type="checkbox"/> A preparer(s) and/or translator(s) assisted the employee in completing Section 1. <i>(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)</i>
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I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	ZIP Code



Employer Completes Next Page



# Temp & Perm



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 08/31/2019

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;"> <p align="center">Additional Information</p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p align="center">Whoever does e-Verify will fill out</p> </div> </div>		<div style="border: 1px solid black; padding: 5px;"> <p align="center">QR Code - Sections 2 &amp; 3 Do Not Write In This Space</p> </div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

**Section 3. Reverification and Rehires** *(To be completed and signed by employer or authorized representative.)*

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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# Temp & Perm

## LISTS OF ACCEPTABLE DOCUMENTS

All documents must be **UNEXPIRED**

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

<b>LIST A</b>	<b>OR</b>	<b>LIST B</b>	<b>AND</b>	<b>LIST C</b>
Documents that Establish Both Identity and Employment Authorization		Documents that Establish Identity		Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are un...ent		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. S...		
		11. C...d		
		12. Day-care or nursery school record		

Collect documents(s)

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Everyone

U.S. Office of Personnel Management Guide to Personnel Data Standards	<b>ETHNICITY AND RACE IDENTIFICATION</b> (Please read the Privacy Act Statement and instructions before completing form.)
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Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)
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Agency Use Only

**Privacy Act Statement**

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Optional for  
Conversions  
if in EOPF  
already

Social Security Number (SSN) is requested under Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. However, other agency sources may be used to obtain it.

**Specific Instructions:** The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

**Question 1. Are You Hispanic or Latino?** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)  
 Yes  No

**Question 2.** Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
<input type="checkbox"/> American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
<input type="checkbox"/> Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Everyone

Designation of Beneficiary

Unpaid Compensation of Deceased Civilian Employee

Important: Read all instructions before filling in this form

A. Identification

Name (Last, first, middle) Date of birth (mm, dd, yyyy) Social Security Number
Department or agency in which presently employed (or former department or agency):
Department or agency Bureau Division Location (City, state and ZIP code)
Depts of the Army & Air Force National Guard of Hawaii Office of TAG (HRO-M) Honolulu, HI 96816-4495

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any unpaid compensation due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) I expressly change or revoke it in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

B. Information Concerning The Beneficiaries (See Examples of Designations):

Table with 4 columns: First name, middle initial, and last name of each beneficiary; Address (including ZIP code) of each beneficiary; Relationship; Share to be paid to each beneficiary. Includes a handwritten note: 'Optional for Conversions if in eOPF already'.

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness Number and street City, state and ZIP code
Signature of witness Number and street City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received Signature Date

Type or print your return address to insure return

Home Address

Perm



# Designation of Beneficiary

Federal Employees Retirement System

Form Approved  
OMB No. 3206-0173

**Important:**  
Read all instructions before filling in this form

## A. Identification

Name (Last, first, middle)		Date of birth (mm/dd/yyyy)	Social Security Number
Place an "X" in the appropriate box: <input checked="" type="checkbox"/> An employee	<input type="checkbox"/> Retired or an applicant for retirement	<input type="checkbox"/> Former employee eligible for retirement in the future	If you are retired give your claim number
Department or agency in which presently employed (or former department or agency):			
Department or agency Depts of the Army & Air Force	Bureau National Guard of Hawaii	Division Office of TAG (HRO-M)	Location (City, state and ZIP code) Honolulu, HI 96816-4495

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees Retirement System (FERS) after my death, including lump-sum death benefits which may become payable based on amounts contributed to the Civil Service Retirement System (CSRS) before I became covered by FERS. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my FERS retirement contributions.

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

## B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary ①	Address (including ZIP code) of each beneficiary ②	Relationship to you ①	Share to be paid to each beneficiary
Date of designation (mm/dd/yyyy)	Your signature		Total = 100%

Optional for Conversions if in EOPF already

## C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Address (including ZIP code)
Signature of witness	Address (including ZIP code)

### Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received by agency (mm/dd/yyyy)	Signature	Date (mm/dd/yyyy)
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① We will pay to the person you designate, even if that person's name or relationship to you changes after you file this designation. For example, suppose you designate your spouse and then you two divorce and you marry someone else. We will pay any lump sum to your former spouse unless you submit another designation to cancel prior designations or to designate who we are to pay.

② We will write to the address you provide here to contact the person you designate. However, that person is obligated to get in touch with us after your death to ask us to make payment.

Type or print your return address so that we can return a copy to you.

See Back of Employee Copy For Instructions  
On Where To File This Form.  
(Retain until employee leaves Federal  
service and then send to the Office of Personnel  
Management [OPM].)



Perm

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the
Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured (Last, first, middle)
Date of birth of Insured (mm/dd/yyyy)
Social Security Number of Insured
The Insured is:
[X] an employee
a retiree
a compensationner
Department or agency where the Insured works (If retired, last department or agency where the Insured worked):
Department or agency: Departments of the Army & Air Force
Bureau or division: NGHI, TAG-HI, HRO-M
Location (city, state, and ZIP code): Honolulu, HI 96816-4495

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

Table with 5 columns: First name, middle initial, and last name of each beneficiary; Social Security Number; Address (Including ZIP code); Relationship; Percent or fraction designated. Includes a handwritten note: 'Optional for Conversions if in EOPF already'.

Total (Must equal 100% or 1.0) (Do not use dollar amounts)
(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address (Including ZIP code)
Please check one:
I am:
[ ] the Insured
[ ] an Assignee
Please check all three:
[ ] I have not assigned the insurance.
[ ] Two people who witnessed my signature signed below.
[ ] I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee (Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.) This form is not valid unless the Insured/Assignee signs in this box.

Date (mm/dd/yyyy)

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness
Address (Including ZIP code)
Signature of witness
Address (Including ZIP code)

E. For Agency Use Only (or OPM, as appropriate)

Receiving agency
Date of receipt (mm/dd/yyyy)
Signature of authorized official
Title

Part 1 - Original

Temp

**MEMORANDUM OF UNDERSTANDING - TEMPORARY APPOINTMENT**

(Revised 15 December 2014)

I, the undersigned, understand that *(please initial next to each item below)*:

1. This appointment is subject to termination at any time without the use of adverse action or reduction-in-force procedures. Notice will be provided by Standard Form 50 (Notification of Personnel Action). Initial

2. A temporary limited employee:

a. Does not acquire permanent status under a temporary limited appointment or eligibility to be noncompetitively converted to a permanent appointment. Initial

b. Does not serve a probationary or trial period. Initial

c. Is not eligible for coverage under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or the Federal Employees Group Life Insurance (FGLI) Program--unless the temporary employment follows, without a break in service in excess of three days, employment in a covered position. In addition, temporary service performed on or after 1 January 1989 is not creditable under FERS even if the employee later becomes covered by FERS. Since I am not currently eligible for a federal retirement program, I may be eligible to enroll in a "myRA" (myRetirement Account) savings account with the U.S. Treasury Department (<https://myra.treasury.gov/>). Initial

d. Is eligible for coverage under the Federal Employees Health Benefits (FEHB) Program when the temporary appointment is expected to be for 90 consecutive days or more in a continuous appointment. Employees may also carry over FEHB coverage when they move from a covered position to a temporary appointment without a break in service in excess of three days. Initial

(1) If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If your appointment is extended without a break in service to 90 or more consecutive days, you will be notified, and information regarding your FEHB eligibility will be provided to you. Initial

(2) Upon eligibility for FEHB, a dual status technician becomes ineligible for TRICARE Reserve Select (TRS) and must contact TRICARE to disenroll in TRS whether or not he/she enrolls in the FEHB. Initial

e. Is not eligible for coverage under the Federal Dental and Vision Program (FEDVIP). However, is eligible to enroll in the Flexible Spending Account (FSA) and the Long Term Care Insurance (FLTCIP) programs. Initial

f. Is not eligible for within-grade increases (WIGI) when serving in a General Schedule (GS) position, even when that temporary limited appointment has been extended beyond one year. An employee serving under a temporary limited appointment in a Federal Wage System (WG/WL/WS) position is eligible for a WIGI when the required waiting periods are met and job performance is fully acceptable or higher. Initial

g. Is eligible to work on a part-time, intermittent, or full-time basis if the agency authorizes such an appointment. Initial

h. Earns leave when appointed to a position with a regularly scheduled tour of duty, either part-time or full-time. All regularly scheduled temporary employees earn sick leave, and those whose temporary appointments are made for 90 consecutive days or more also earn annual leave. Temporary employees serving on temporary limited appointments not to exceed one year are not eligible for military leave. Extensions of or continuous consecutive temporary appointments, which result in more than one year of consecutive service are also not eligible for military leave since each extension or conversion action is considered a new appointment for military leave purposes. Initial

i. Is not covered by adverse action procedures under 5 USC 4303 and 5 USC 7511 even when converted to a new temporary limited appointment with total service extending beyond one year because each temporary appointment is always limited to one year or less. Initial

j. Does not have the protection of reduction-in-force procedures. Initial

3. The regulations that govern the employment of National Guard technicians require membership in an appropriate National Guard unit as a condition of employment. This requirement is derived from Section 709(f)(1), Title 32, United States Code. I certify that I understand that my full-time technician position with the Hawaii Air/Army National Guard is contingent upon my maintaining membership with the Hawaii Air/Army National Guard. Should I lose my membership for any reason, I will be terminated from my full-time technician position. Initial

4. Dual-Status military technicians are required to wear the uniform appropriate for the member's grade and component of the armed services while performing duties. The uniform will be worn in compliance with the regulations issued by the applicable military component. Initial

Please sign and date below to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).

Signature

Printed Name

Date