



Individually Billed Account Travel Card Set Up Form

Citi[®] Government
Travel Card Program

Instructions:

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

See pages 2-3 for detailed instructions on completing this form.

Date:	
Attention:	
Fax:	866-671-5910 605-338-5745

Section I: Cardholder Information (* = Required Fields)

1. Cardholder Name *	Provide first, middle and last name of the applicant as it should appear on the card. (maximum of 19 characters - including spaces)											
2. Cardholder Contact Details	Mail to Attention *	a) HM-15 PERSONNEL					b)					
	Primary Address *	A physical address must also be provided if a P.O. Box is your primary mailing address. Enter this address in the section titled "Home Mailing Address". Applications providing only a P.O. Box will not be processed. For APO/FPO addresses only, a physical address is not required.					Home Mailing Address (No Post Office Box)					
	Address Line 1 *	NAVAL STATION					Address Line 1:					
	Address Line 2:	1130 CV TOW WAY DRIVE					Address Line 2:					
	City or APO/FPO *	NORFOLK			State *	VA		City or APO / FPO:			State:	
	Zip/Postal Code *	23511		Country *	US		Zip/Postal Code:			Country:		
Commercial Office Phone *	(757) 322-9656			Home Phone *				Email Address:				
3. Cardholder SSN *												
	4. Date of Birth * (mm/dd/yyyy)											

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

Signature & Agreement *	By signing below, I: (i) acknowledge I have read the Citi [®] Department of Defense Services Travel Card Program Cardholder Agreement; (ii) agree to be bound by the terms and conditions as set forth in the Agreement; and (iii) understand that only the Department of Defense may request particular Authorization Parameters (Section III). This application is for a Department of Defense Travel Card account, which may be standard or restricted, as described in the Cardholder Agreement. I expressly agree to accept whichever type of account is established. Pursuant to requirements of law, including the U.S.A. Patriot Act, the bank is required to request additional information to verify your identity.									
	5. Applicant's Signature *					6. Date *				
	7. Credit Report Authorization * (initial one)					8. Date *				
	A. _____ I, as the cardholder, authorize the bank to obtain credit reports on me as described in the agreement					B. _____ I, as the cardholder, DO NOT authorize the bank to obtain credit reports on me. Therefore, I will not be eligible for a standard card.				
	8. Approving Supervisor's Signature *					9. Date *				

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

Account Specifications	10. <input type="checkbox"/> Restricted by APC (See detailed instructions page 2-3)	a) Date to Activate (mm/dd/yyyy):					b) Date to Deactivate (mm/dd/yyyy):										
	11. Plastic Type * (select one)	<input type="checkbox"/> Government Standard <input checked="" type="checkbox"/> Quasi-Generic					12. Delivery * (select one) <input checked="" type="checkbox"/> Standard <input type="checkbox"/> Expedited (\$20 delivery fee)										
	13. Central Account Number	4	6	1	4	7	1	0	0	0	0	0	0	0	2	3	9

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

14. Citi Account Hierarchy *	Specify the complete 5-digit account Hierarchy Level (HL) numbers that pertains to your organization. Each Hierarchy Level consists of 5 digits.																													
	HL1	HL2	HL3	HL4	HL5	HL6	HL7																							
	2	0	0	0	1	2	2	0	0	0	3	2	6	0	0	4	2	1	3	4	5	3	0	2	9	6	3	1	8	3

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

15. Authorized APC *	By signing below, I hereby authorize, on behalf of the Agency/Organization indicated above, that a Department of Defense Travel Card be issued to the employee named in Section I of this application. PLEASE RETAIN A COPY FOR YOUR RECORDS.										
	APC *	Name (type or print)					Signature *			Date *	
	Commercial Phone *	757-444-					Commercial Fax *: (757) 444-2246				
	Zip / Postal Code *	23511					Email *				

Global Transaction Services

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HELMINERON FIFTEEN CHECK-IN/CHECK-OUT SHEET (E6 & below)

<u>Rate/Rank and Name</u>	<u>XXX-XX- Social Security Number</u>	<u>Date Check-in/Check-out</u>
<u>Work Center</u>	<u>Duty Section</u>	322-9656/9657 Duty Phone
		ADMIN USE ONLY Tracking #

Sponsor _____

You are directed to check in and check out with the following personnel as applicable. Completion of this form is mandatory in order to ensure proper accounting of personnel. Report to the HM-15 Personnel Office prior to checking in or out and return this form (completed with necessary signatures) within 5 days.

<u>ALL PERSONNEL</u>	<u>IN</u>	<u>OUT</u>	<u>AIRCREW/ MCM MAINT/ AIRCRAFT MAINT</u>	<u>IN</u>	<u>OUT</u>
Personnel Office (Recall) (RM-230)			Aircrew Training (Aircrew)		
PASSPORT - Mbr already has No Fee Passport - YES / NO			Aircrew LCPO (Aircrew)		
If No, start processing w/ personnel (RM-230)			Operations (Aircrew)		
TEMADD Clerk (Visa Travel Card) (RM-230)			*SHARP data on disk		
ESO (RM-231)			*Medical up chit		
Family Care Coordinator (RM-230)			NATOPS (Aircrew)		
Legal Officer (RM-230)			*Turn in NATOPS Jacket		
Mentorship Program Coordinator (E5 and Below)			*Pubs issue		
CCC (RM-209)			*Bring pubs if already issued to reserialize and to ensure up-to-date interim changes		
Senior Section Leader			OOMA Sys ADM (Maint Cntrl) (Aircrew)		
*Assigned Section			Support Equip PO (Tac Sup) (Aircrew)		
Duty Section Leader			Quality Assurance (RM-103) (Maint)		
CMC (RM-202)			Manpower Coordinator (RM-114)		
Command Training (RM-202)			Ordance/Certification (RM-115) (AO's/Aircrew)		
DAPA W/Med Record (RM-201)			HAZMAT Coordinator (RM-122)		
XO (E6)			Tool Room (RM-122) (Maint)		
Department Head			Maintenance Training (RM-128)		
Security Mgr (RM-223)			Maint/MCM Admin (RM-128/129)		
COMMS (NMCI account) (RM-214)			*check-in prior to checking with the division		
*Complete Info Assurance Awareness Trng on NKO			Division Officer		
TAC Support (RM-100)			Safety Office (RM-123)		
*Get a government white license for duty driver			*Issue Topsy Taxi Card		
*CBR fitting			*Perform a risk assessment		
Fitness Coordinator (AT2 Conley)			*Complete ORM course on NKO within 30 days		
*BCA Measurements			- ORM All Navy Essentials for Leaders (E-5 and above)		
Urinalysis Coordinator (RM-122)			- ORM All Navy Fundamentals (All Hands)		
Material Control (RM-126)			*Sign page 13 for motorcyclists		
*Issue boots for DET II			*Database personal information (i.e. cpr/hearing tests/vision/etc.)		
Occupational Health			ESD MGR (for 200 Div/16B)		
Medical (1400-1500 everyday, except Thursday)			Paraloft (RM-110)		
*HM-15 Medical, MCM hangar			*Bring training jackets for EGRESS training		
*Bring medical record			*Aircrew bring NATOPS and all flight gear including dry suit		
Tricare Regional Enrollment					
Dental (Sewells Point Dental Clinic)					
*Bring dental record					

HM-15 RECALL

NAME (LAST NAME, FIRST NAME):

RATE/RANK:

ADDRESS:

PHONE NUMBER:

DEPARTMENT/DIVISION:

DUTY SECTION (IF APPLICABLE):

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- Name or update your beneficiary
- Reduce the amount of your insurance coverage
- Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name	First name	Middle name	Rank, title or grade	Social Security Number
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Branch of Service (Do not abbreviate)	Current Duty Location
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Amount of Insurance

By law, you are automatically insured for \$400,000. **If you want \$400,000 of insurance**, skip to *Beneficiary(ies) and Payment Options*. **If you want less than \$400,000** of insurance, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$50,000. **If you do not want any insurance***, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

Declining SGLI coverage also cancels all family coverage and traumatic injury protection under the SGLI program.

- I want coverage in the amount of \$ _____ Your initials _____
- _____ (Write "I do not want insurance at this time.")

*Note: Reduced or refused insurance can only be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements. Reduced or refused insurance will also affect the amount of Veterans' Group Life Insurance you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1.				
2.				
3.				
4.				
<input type="checkbox"/> Additional Principals on page 4 (check if applicable)				
Contingent				
1.				
2.				
3.				
4.				
<input type="checkbox"/> Additional Contingents on page 4 (check if applicable)				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- This form cancels any prior beneficiary or payment instructions.
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$400,000.
- If I am married or If I get married after completing this form, **my spouse is automatically covered under Family SGLI for which premiums will be deducted from my pay**, unless I decline Family SGLI coverage by completing SGLV 8286A. For Family SGLI premium deductions, my spouse **MUST** be registered in DEERS. Failure to do so will result in debts owed for unpaid premiums.

SIGN HERE IN INK _____ Date: _____
 (Your signature. Do not print.)

Do not write in space below. For official use only.

RECEIVED BY:	RANK, TITLE OR GRADE	ORGANIZATION	DATE RECEIVED
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Please read the instructions before completing this form.

Family Coverage Election

Servicemember's Information

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Date of Birth	Social Security Number
Branch of Service (Do not abbreviate)				Rank, title or grade	
Navy					

Amount of Insurance

Family Coverage for Dependent Child(ren). By law, if you are insured under SGLI, each of your dependent children (see page 3 for a definition of dependent children for SGLI purposes) is automatically insured for \$10,000.

Family Coverage for Spouse. By law, if you are insured under SGLI, **your spouse is automatically insured for \$100,000 or the amount of your SGLI coverage, whichever is less.** *If you want less than the automatic amount of coverage for your spouse*, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. *If you do not want any coverage for your spouse**, check the appropriate block below and write (in your own handwriting), "I do not want coverage for my spouse at this time."

I want coverage in the amount of \$ _____

(Write "I do not want coverage for my spouse at this time.")

*Note: Reduced or refused family coverage can *only* be restored by completing form SGLV 8285A with proof of good health and compliance with other requirements. It will also affect the amount of insurance your spouse can convert when Family Coverage expires.

Spouse's Information

(To be completed by member. It is not necessary to complete this section if you're declining coverage.)

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number
Date of Birth (dd-mmm-yyyy e.g. 24-AUG-1965)				

Premiums for Spousal Coverage

Spouse's age:	Monthly rate per \$10,000	Monthly cost for \$100,000 coverage
Under 35	\$.55	\$5.50
35-39	\$.70	\$7.00
40-44	\$.90	\$9.00
45-49	\$1.40	\$14.00
50-54	\$2.70	\$27.00
55-59	\$4.00	\$40.00
60 & older	\$5.20	\$52.00

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form and certify that the information I have provided is correct.

SIGNATURE OF SERVICEMEMBER _____ Date: _____
(dd-mmm-yyyy e.g. 01-NOV-2001)

Do not write in space below. For official use only.

Received by: (please print)	Rank, title or grade	Organization	Date Received (dd-mmm-yyyy e.g. 01-NOV-2001)
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NO-FEE PASSPORT REQUIREMENTS

1. DD FORM 1056:

AUTHORIZATION TO APPLY FOR NO-FEE PASSPORT/VISA (MUST BE TYPED & SIGNED IN BLUE INK)

2. PHOTOGRAPHS:

TWO (2) IDENTICAL 2" X 2" PASSPORT PHOTOS (must be in civilian attire)

Photos are no longer available on Naval Station Norfolk or Naval Air Station Oceana.
Photos may be obtained in town at various locations such as Walgreens, Eckerds, Kinkos, Sears, etc....

3. PROOF OF CITIZENSHIP:

ORIGINAL BIRTH CERTIFICATE (Must contain the following):

NAME OF THE CHILD

DATE OF BIRTH

PLACE OF BIRTH

DATE CERTIFICATE FILED IN THE REGISTRAR'S OFFICE (must be within one year of birth)

SIGNATURE OF REGISTRAR AND AUTHORIZED SEAL OF REGISTRAR'S OFFICE

(Seal may be RAISED, EMBOSSED, IMPRESSED, OR MULTICOLORED).

HOSPITAL BIRTH CERTIFICATES ARE NOT ACCEPTABLE.

OR

PREVIOUS PASSPORT (MUST BE A FULL VALIDITY PASSPORT) (Tourist-10yrs) (No-Fee-5yrs)

***NOTE: IF IN POSSESSION OF A TOURIST PASSPORT, PLEASE BRING IT IN FOR INFORMATIONAL PURPOSES EVEN IF IT IS NOT BEING SUBMITTED AS PROOF OF CITIZENSHIP.

OR

ORIGINAL CERTIFICATE OF NATURALIZATION (MUST BE THE ORIGINAL)

All proof of citizenship submitted will be mailed with application to the State Department (NO EXCEPTIONS) and will be returned with the completed passport.

***Please bring any passport (TOURIST OR NO-FEE, VALID OR EXPIRED) that has been issued to you and is in your possession.

4. DS FORM 11: (PASSPORT APPLICATION)

MUST be completed online at WWW.TRAVEL.STATE.GOV.

ONCE YOU HAVE ACCESSED THE WEB PAGE, CLICK ON THE PASSPORTS BUTTON (TOP/MIDDLE), THEN CLICK THE BUTTON THAT SAYS "FORMS" (LEFT/MIDDLE). DO NOT CLICK ON "PASSPORT APPLICATION: DS-11." THEN CLICK THE LINK THAT STATES, "PASSPORT APPLICATION WIZARD. CHECK THE DISCLAIMER BOX AND THE SUBMIT BUTTON. NOW CLICK THE SUBMIT BUTTON UNDER THE "APPLY ONLINE" OPTION. NOW ENTER ALL YOUR PERSONAL INFORMATION. ***NOTE*** IF YOU HAVE PREVIOUSLY BEEN ISSUED A U.S. PASSPORT, IN THE FIELD THAT ASKS "IS YOUR MOST RECENT PASSPORT BOOK CURRENTLY IN YOUR POSSESSION?" CHECK "OTHER" (DO NOT CHECK "YES") AND THEN TYPE EITHER "RETAINED" OR "SUBMITTED" IN THE BOX TITLED "PLEASE EXPLAIN". AFTER INFO IS REVIEWED, CLICK THE "NEXT BUTTON" AND THEN CLICK THE OPTION FOR PASSPORT BOOK FEE (\$110.00) ONLY. (YOU WILL NOT BE CHARGED!) CLICK THE "NEXT" BUTTON, THEN CLICK THE ACKNOWLEDGEMENT BOX, THEN CLICK THE "CREATE FORM" BOX, AND THEN PRINT THE DS-11.

After printing, the DS-11 MUST have a 2-D bar-code in the top left corner of page 1 of 2 or it will NOT be accepted. NO EXCEPTIONS!!!

All Children must be present for application processing

Children 16 YRS. OF AGE OR OLDER MUST EXECUTE THEIR OWN PASSPORT APPLICATION.

Children under age 16 MUST HAVE BOTH BIRTH PARENTS PRESENT.

(IF ONLY ONE PARENT AVAILABLE, PLEASE CONTACT US AT 445-4416/4409 FOR GUIDANCE).

5. IDENTIFICATION:

MILITARY ID CARD (for all active duty and dependents)

CAAC & DRIVER'S LICENSE (for all civil service employees and dependents)

6. SOCIAL SECURITY NUMBERS: FOR ALL APPLICANTS

(Federal Tax Law SECTION 6039E of the Internal Revenue Code of 1986 Requirement)

FOR FURTHER INFORMATION, PLEASE CALL (757) 445-4416/4409
CUSTOMER SERVICE HOURS ARE 0730-1500 MONDAY - FRIDAY

Rev 04/2010

Effective July 13, 2010