REQUEST FOR PAYMENT OF FUNERAL AND/OR INTERMENT EXPENSES

OMB No. 0704-0030
OMB approval expires
May 31, 2006

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0030). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE ADDRESS IN ITEM 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488; EO 9397.
PRINCIPAL PURPOSE: To record amount of funeral and/or interment expenses incurred by next of kin.
ROUTINE USES: None.
DISCLOSURE: Disclosure of requested information is voluntary; however, if not furnished, claim cannot be paid.

PART I - TO BE COMPLETED BY MILITARY AUTHORITIES

1. MILITARY ACTIVITY PREPARING THIS FORM	2. MILITARY ACTIVITY FORM IS TO BE MAILED TO FOR PAYMENT
a. NAME	a. NAME
b. ADDRESS *(Street, City, State and ZIP Code)*	b. ADDRESS *(Street, City, State and ZIP Code)*

3. NAME OF DECEDENT *(Last, First, Middle Initial)*	4. PAY GRADE/RANK	5. SERVICE NUMBER/SSN
6. PLACE OF DEATH *(City, State, Country)*		7. DATE OF DEATH *(YYYYMMDD)*
8. NAME OF CLAIMANT *(Last, First, Middle Initial)*		9. RELATIONSHIP

10. FUNERAL HOME AND/OR NATIONAL CEMETERY

a. NAME	b. ADDRESS *(Street, City, State and ZIP Code)*

11. GOVERNMENT CONTRACT FOR CARE OF REMAINS IN EFFECT AT PLACE OF DEATH

☐ NO ☐ YES *(Enter name of contracting activity)*

PART II - TO BE COMPLETED BY CLAIMANT *(Proper completion will expedite settlement.)*

a. Complete Items 12 and 13.
b. Complete either Item 14, 15, or 16. *(Do not complete more than one.)*
c. Complete Item 17, when cost of shipment of remains is claimed in Item 15 or as Item 16.
d. Attach copies of bills for all amounts claimed.
e. Mail completed form to addressee shown in Item 2.

12. CEMETERY, MAUSOLEUM OR OTHER DISPOSITION		13. DATE OF INTERMENT *(YYYYMMDD)*
a. NAME	b. ADDRESS *(Street, City, State and ZIP Code)*	

	AMOUNT CLAIMED
14. INTERMENT COSTS *(To be completed when claimant arranged for interment only.)* Enter total amount paid or incurred for one or more of the following: Cost of single grave site, opening and closing grave, burial vault, church service or clergy's fee, obituary notice, flowers, services of funeral director, including use of funeral director's facilities, and motor service.	$
15. FUNERAL ARRANGEMENT COSTS *(To be completed when claimant made all arrangements.)* Enter total amount paid or incurred for one or more of the following: Casket, preservation (embalming) and related services, cremation and urn, clothing for deceased, cost for interment (single grave site, opening and closing grave, burial vault, church service or clergy's fee, obituary notice, flowers, services of funeral director, including use of funeral director's facilities, and motor service), and shipment of remains (removal from place of death to preparation point, delivery from preparation point to common carrier, shipping costs, removal from common carrier to receiving funeral home, and delivery to cemetery).	$
16. SHIPPING COSTS OF REMAINS *(To be completed when claimant paid or incurred cost for shipment of remains.)* Enter total amount paid or incurred for one or more of the following: Removal from place of death to preparation point, delivery from preparation point to common carrier, shipping costs, removal from common carrier to receiving funeral home, and delivery to cemetery.	$

17. SHIPMENT OF REMAINS *(Complete when shipping costs claimed.)*

a. SHIPPED FROM *(City and State)*	b. SHIPPED TO *(City and State)*	c. MODE OF SHIPMENT *(X one)* ☐ AIR ☐ HEARSE

18. STATEMENT OF CLAIMANT: I have paid or incurred expenses in the amounts entered in Items 14, 15, and/or 16. I desire that the amount allowable by the Government be paid to:

a. NAME OF PAYEE *(Print or type)*		b. TAXPAYER ID NUMBER OR SSN
c. ADDRESS OF PAYEE *(Street, City, State and ZIP Code)*	d. SIGNATURE OF CLAIMANT	e. DATE SIGNED

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