DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

# ADMINISTRATIVE REMARKS

**PRIVACY ACT STATEMENT**

Pursuant to 5 U.S.C. §552a(e)(3), this Privacy Act Statement serves to inform you of why DHS is requesting the information on this form.

**AUTHORITY**: 14 U.S.C. § 505

**PURPOSE**: To document a USCG service member's achievements, accomplishments, Uniform Code of Military Justice (UCMJ) infraction(s), or any other USCG military pay or personnel activity.

**ROUTINE USES:** Authorized USCG officials will use this information to validate a USCG service member's achievements, accomplishments, UCMJ infraction(s) or any other USCG military pay or personnel activity. Any external disclosures of information within this record will be made in accordance with DHS/USCG-014, Military Pay and Personnel, 76 Federal Register 66933 (October 28, 2011).

**CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION:** Providing this information is voluntary. However, failure to provide this information may result in a delay in administrating this form.

Entry Type: Reserve Incapacitation Benefits (RIB-4)
Reference: Reserve Duty Status and Participation Manual, COMDTINST M1001.2;
Reserve Policy Manual, COMDTINST M1001.28 (Series)
Responsible Level: Unit or SPO
Entry: I, , was counseled on_____regarding my decision to be released from Active Duty prior to resolution of my Line of Duty (LOD) medical condition.

1. _____ (Initials) I understand that if I consent to remain on Active Duty for medical care, my care will be coordinated through a Military Treatment Facility (MTF).

2. _____ (Initials) I understand that while on orders greater than 30 days, TRICARE is available for my family and I.

3. _____ (Initials) I understand that while on Active Duty I will receive pay and allowances to the same extent permitted by law for regular component members.

4. _____ (Initials) I understand that I may be eligible to remain on Active Duty until I am Fit for Full Duty (FFFD) or separated/retired by the Physical Disability Evaluation System (PDES).

5. _____ (Initials) I understand all the above and I am requesting to be released from Active Duty.

6. _____ (Initials) I understand that I may request a Notice of Eligibility (NOE) for continued medical care to be coordinated by a CG MTF. If authorized, the NOE will only cover medical care for a specific LOD condition.

7. _____ (Initials) I understand that if a NOE is authorized, I may be eligible for incapacitation pay and that claims are paid in arrears. Payment requests cannot exceed 30 days and payment processing may take an additional 30 days. If I am relying on incapacitation pay claims for income, I must be financially secure for at least 60 days.

8. _____ (Initials) I understand that when I am released from Active Duty, my family and I may no longer be eligible for TRICARE benefits. (This does not apply to those personnel with Transitional Assistance Management Program (TAMP) or TRICARE Reserve Select (TRS) benefits).

9. _____ (Initials) I certify that this release from Active Duty is voluntary and I have not been coerced into voluntary separation. I have been thoroughly counseled on this voluntary release and all my concerns have been addressed to my satisfaction.

My current contact information is: Home Phone: (_____)_____-_____ Work Phone: (_____)_____- _____

Email: _____

_____ (Signature of Member / Date)

_____ (Signature of Counselor / Date)

_____ (Printed Name of Counselor)

| 1. NAME OF PERMANENT UNIT | 2. NAME OF UNIT PREPARING THIS FORM | |
|---|---|---|
| 3. NAME OF MEMBER (Last, First, MI) | 4. EMPLOYEE ID NUMBER | 5. GRADE/RATE |

**Scan original into member's OMPF**