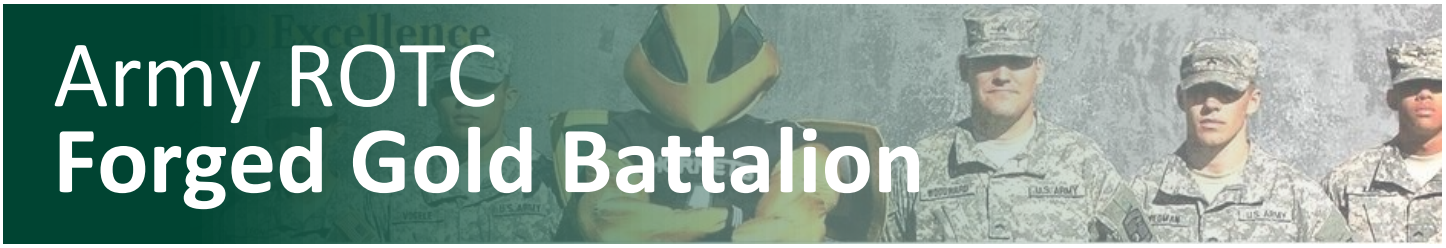

Army ROTC
Forged Gold Battalion

Army ROTC Contract Packet Instructions

Step 1: Please download this packet to your personal computer.
Step 2: Then complete the Data Entry page of this packet, everything else will autofill.
Step 3: Once you have filled out all required information, sign in the red signature boxes.
The pages requiring signatures have been bookmarked as well;

a. Page 3 sign SF 1199A (Direct Deposit Form)
b. Page 5 sign DD 93 (Emergency Record Card)
c. Page 6 [Complete Section 2]
d. Page 7 [Complete Section 4; Yes/No questions]
e. Page 8 sign SLGI
f. Page 9 sign DD 2058
g. Page 10 sign W-4 (2020)

Step 4: Save this PDF as your Last Name Contract Packet
EX: Herky Contract Packet
Step 5: Email this completed packet and the following applicable items to armyrotc@csus.edu;

a. If you are currently enlisted, make sure you email a copy of the completed form;
    i. Reserves: DA 4824-R
    ii. National Guard: NGB 594-1

If you have any questions, please do not hesitate to email us at armyrotc@csus.edu

Content Updated 05/26/2020 ASG

Full Name (Last, First, Middle Initial): Today's Date:

First Name: Middle Initial: Last Name:

Campus Email: **Full Mailing Address:**
Street Address, City, State, Zip Code

Street Address: Apt/Suite #:

City: State: Zip Code:

Personal Phone Number (enter numbers in only):

Social Security Number (enter numbers in only):

Date of Birth (YYYY-MM-DD):

Sex: Male Female Height (in inches): ins. Weight (in pounds): lbs.

Please select one: Married Single Divorced Widowed

If Married, spouse's name: Spouse's Date of Birth: 05/04/2020
Last Name, First Name, Middle Initial *(MM/DD/YYYY)*

Do you have Children?

Name: (Last, First, MI)	Relation to you	Date of Birth	Current Address & Phone Number
			Street Address, City, State, Zip Code
			Phone Number (Numbers only)

Father name (Last, First, MI): **Mother name (Last, First, MI):**

Address & Phone #: **Address & Phone #:**

Do not notify if ill: **Notify Instead:**
Last Name, First Name, Middle Initial *Last Name, First Name, Middle Initial*

Primary & Secondary Beneficiary

	Relation	Share %	Payment Option
Ptimary's Name: *Last Name, First Name, Middle Initial*			
their address: *Street Address, City, State, Zip Code*			
Secondary's Name: *Last Name, First Name, Middle Initial*			
their address: *Street Address, City, State, Zip Code*			

Service Group Life Insurance

$0

Your Direct Deposit Information

Pick your account type

Checkings **Savings**

Account Deposit Number

Bank Name & Address

Routing Number

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

GOVERNMENT AGENCY COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 552, 10 USC 655, 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397 (SSN).
PRINCIPAL PURPOSES: This form is used by military personnel and Department of Defense civilian and contractor personnel, collectively referred to as civilians, when applicable. **For military personnel**, it is used to designate beneficiaries for certain benefits in the event of the Service member's death. It is also a guide for disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the Service member desires to be notified in case of emergency or death. **For civilian personnel**, it is used to expedite the notification process in the event of an emergency and/or the death of the member. The purpose of soliciting the SSN is to provide positive identification. All items may not be applicable.
ROUTINE USES: None.
DISCLOSURE: Voluntary; however, failure to provide accurate personal identifier information and other solicited information will delay notification and the processing of benefits to designated beneficiaries if applicable.

INSTRUCTIONS TO SERVICE MEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty (other family members or fiance), and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other personnel listed, for example, as a result of marriage, civil court action, death, or address change.

INSTRUCTIONS TO CIVILIANS

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty. Not every item on this form is applicable to you. **This form is used by the Department of Defense (DoD) to expedite notification in the case of emergencies or death.** It does not have a legal impact on other forms you may have completed with the DoD or your employer.

IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information and Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.

SECTION 1 - EMERGENCY CONTACT INFORMATION

1. NAME *(Last, First, Middle Initial)*	2. SSN

3a. SERVICE/CIVILIAN CATEGORY	b. REPORTING UNIT CODE/DUTY STATION
[X] ARMY [ ] NAVY [ ] MARINE CORPS [ ] AIR FORCE [ ] DoD [ ] CIVILIAN [ ] CONTRACTOR	W0CF05/ UC DAVIS

4a. SPOUSE NAME *(If applicable) (Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER
[ ] SINGLE [ ] DIVORCED [ ] WIDOWED	

5. CHILDREN a. NAME *(Last, First, Middle Initial)*	b. RELATIONSHIP	c. DATE OF BIRTH *(YYYYMMDD)*	d. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

6a. FATHER NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

7a. MOTHER NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

8a. DO NOT NOTIFY DUE TO ILL HEALTH	b. NOTIFY INSTEAD

9a. DESIGNATED PERSON(S) *(Military only)*	b. ADDRESS *(Include ZIP Code)* AND TELEPHONE NUMBER

10. CONTRACTING AGENCY AND TELEPHONE NUMBER *(Contractors only)*

SECTION 2 - BENEFITS RELATED INFORMATION

11a. BENEFICIARY(IES) FOR DEATH GRATUITY *(Military only)*	**b. RELATIONSHIP**	**c. ADDRESS** *(Include ZIP Code)* **AND TELEPHONE NUMBER**	**d. PERCENTAGE**

12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES *(Military only)* **NAME AND RELATIONSHIP**	**b. ADDRESS** *(Include ZIP Code)* **AND TELEPHONE NUMBER**	**c. PERCENTAGE**

13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD) *(Military only)* **NAME AND RELATIONSHIP**	**b. ADDRESS** *(Include ZIP Code)* **AND TELEPHONE NUMBER**

14. CONTINUATION/REMARKS

15. SIGNATURE OF SERVICE MEMBER/CIVILIAN *(Include rank, rate, or grade if applicable)*	**16. SIGNATURE OF WITNESS** *(Include rank, rate, or grade as appropriate)*	**17. DATE SIGNED** *(YYYYMMDD)*

Prudential

Office of Servicemembers' Group Life Insurance

Servicemembers' Group Life Insurance Election and Certificate

The SGLI Online Enrollment System (SOES) is the official system of record for Servicemembers' Group Life Insurance for the United States Navy, the United States Army and the United States Air Force. All coverage and beneficiary elections for members of the Navy, the Army and the Air Force should be made in SOES. This form should only be used in special circumstances as defined by the United States Navy, the United States Army and the United States Air Force.

1. About You

	CD	
Print Name (First, Middle, Last)	Rank, title or grade	Social Security Number
UNIVERSITY CALIFORNIA, DAVIS	ARMY	$0
Duty Location	Branch of Service	Current Amount of SGLI
☐ Married ☐ Single		05/04/2020
	If married, spouse's name	Spouse's Date of Birth

2. About Your Coverage *This form replaces all prior designations.*

I am completing this form to: (Check all that apply)

- ☐ Name or update my SGLI beneficiary. *You must complete sections 3 & 5.*
- ☐ Increase or restore my SGLI coverage to **$**_____. *You must complete sections 3, 4, & 5. (Increasing SGLI does not automatically increase FSGLI, if FSGLI was < $100,000.)*
- ☐ Reduce my SGLI coverage to **$**_____. *You must complete sections 3 & 5.*
- ☐ Decline or cancel SGLI coverage. Write below "I do not want insurance at this time." *You must complete section 5 only.*
  " _____ **"**.

SGLI coverage is available in increments of $50,000 up to a maximum of $400,000. Traumatic Injury Protection (TSGLI) coverage is automatic with SGLI coverage.

3. About Your Beneficiaries *Please always complete this section unless you are declining coverage. If you do not specifically name beneficiaries, your insurance will be paid by law. Please read the information on page 3 before selecting your beneficiaries.*

Primary **Name and Address**	Social Security Number *(If available)*	Relationship to you	Share to each (%) – *The sum of shares must equal 100%. **Each share must be greater than 0%.***	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				
2.				
3.				
4.				

Secondary **Name and Address**	Social Security Number *(If available)*	Relationship to you	Share to each (%) – *The sum of shares must equal 100%. **Each share must be greater than 0%.***	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				
2.				
3.				
4.				

☐ **Have more beneficiaries?** Check this box if 1) You have additional beneficiaries and are completing the Supplemental SGLI Beneficiary Form, SGLV 8286S or, 2) You are attaching additional documentation to complete your beneficiary designation noted above.

*If the insured member elects a lump sum payment, the beneficiary(ies) will be given the option of receiving the lump sum payment through the Prudential Alliance Account®, by check, or Electronic Funds Transfer (EFT). Alliance Account is not available for payments less than $5,000, payments to individuals residing outside the United States and its territories, and certain other payments. These will be paid by check.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

4. About Your Health *Complete this section ONLY if you are restoring or increasing coverage.*

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender ☐ Female ☐ Male

Have you had, been treated for, or had known indications of:	**Yes**	**No**
a. A heart condition?	☐	☐
b. High blood pressure?	☐	☐
c. A neurological disorder?	☐	☐
d. Diabetes?	☐	☐
e. Cancer or tumors?	☐	☐
f. Have you ever been diagnosed as having a disease of the immune system?	☐	☐
g. Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below. Please attach additional documentation if necessary.

If you answered "yes" to any question above, a request to increase coverage does not take effect until approved by the Office of Servicemembers' Group Life Insurance (OSGLI). If you answered "no" to all the questions above, your request for increased coverage takes effect immediately.

5. Your Signature *You must complete this section.*

I have read the information on page 3 and instructions on page 4 and understand that:

- This form replaces any prior beneficiary or payment instructions.
- I can have SGLI and Veterans' Group Life Insurance (VGLI) at the same time, but the combined amount cannot be more than $400,000. VGLI is lifetime renewable post-separation coverage available to Service Members who separate with SGLI coverage.
- Reducing SGLI coverage can affect the amount of my family coverage (FSGLI) and VGLI coverage (see instructions on page 4).
- By declining or canceling SGLI coverage, I am also declining family coverage (FSGLI) and Traumatic Injury Protection (TSGLI). I am also not eligible for any post-separation coverage (see instructions on page 4).

Please take note:

If my spouse is…	and…	then…
also a member of the uniform services	we married on or after January 2, 2013	spouse SGLI coverage is not automatic, but I may apply for spouse coverage by completing SGLV 8286A.
not a member of the uniformed services	I am married, or get married after completing this form, and have not declined SGLI,	spouse SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. Failure to do so will result in a debt for unpaid premiums. I can decline spouse coverage by completing SGLV 8286A.

- I am free to name anyone I want as my beneficiary. I understand if I am married and have designated someone other than my spouse or child as my beneficiary, the person I have named is the person I intend to receive my insurance proceeds. I also understand that my spouse may be notified that he/she (or my child) is not my designated beneficiary.

I certify that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits. If declining or reducing SGLI coverage, I have received the appropriate general information concerning life insurance from my Unit Personnel Clerk.

Service Member Signature	Social Security Number	Date Signed (MM, DD, YYYY)

Address

Submit this form to your Unit Personnel Clerk. By completing this section the Unit Personnel Clerk acknowledges that they have counseled the Service Member in regards to the information provided on page 4 of this form.

For Branch of Service Use Only		For OSGLI Use Only
Name of Personnel Clerk	Jennifer Greene (CSUS)	Representative
Rank, title or grade	HRA	Approve ☐
Contact telephone/email	(916)278-7682/j.greene@csus.edu	Disapprove ☐
Date		Date
Address	6000 J Street, YSM 155, Sacramento, CA, 95819	

STATE OF LEGAL RESIDENCE CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Tax Reform Act of 1976, Public Law 94-455.

PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

ROUTINE USES: Information herein will be furnished State authorities and to Members of Congress.

MANDATORY OR VOLUNTARY DISCLOSURE: Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

NAME *(Last, first, middle initial)*	**SOCIAL SECURITY NUMBER** *(SSN)*

LEGAL RESIDENCE/DOMICILE *(City or county and State)*

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile. In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend on legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

SIGNATURE	**CURRENT MAILING ADDRESS** *(Include ZIP Code)*	**DATE**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $

Multiply the number of other dependents by $500 . . . . ▶ $

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.)

▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)