



# **2026 PHA & SRP DIGITAL PACKAGE**



GOVERNMENT OF PUERTO RICO  
PUERTO RICO NATIONAL GUARD  
STATE GUARD COMMAND  
Tabonuco #2 GAM Tower  
San Patricio, Guaynabo, Puerto Rico 00968

PRSG-CAO

19 December 2025

MEMORANDUM FOR RECORD

SUBJECT: Required Documents for the Soldiers Readiness Program (SRP) and Periodic Health Assessment (PHA) for Active Members of the Puerto Rico National Guard - State Guard Command.

1. The following documents must be presented during the SRP/PHA:
  - a. PRSG FORM 2807-1 Medical History (**Documents completed digitally via ([www.prsg.us](http://www.prsg.us))**
  - b. PRSG FORM 93 Record of Emergency Data. (**Documents completed digitally via ([www.prsg.us](http://www.prsg.us))**
  - c. Certificate of Penal Record. It is requested online and arrives the same day by email. (<https://www.pr.gov/antecedentes-penales>). The printed document must not be more than 30 days old.
  - d. ASUME Certificate. It is requested online and arrives the same day by email. (<https://app.asume.pr.gov/>). The printed document must not be more than 30 days old.
  - e. Driver's License - Printed on both sides, enlarged.
  - f. Military ID (PRSG) - Printed on both sides, enlarged.
  - g. Complete the FIGNA Life Insurance Beneficiary Form, as applicable.
  - h. Completion of the four (4) Mandatory Briefings. (<http://www.prsg.us>)
  - i. BTC (IETC) Certificate.
  - j. Certificates from Military Schools / PME.
  - k. MEMS certificates, as applicable.
  - l. Any Badges or Diplomas obtained during the year.
2. Soldiers will be notified through the Chain of Command of the location and time at which they are required to report with the required documents.
3. If you have any doubts or concerns on this matter, do not hesitate to contact us.
4. The point of contact for this matter is by telephone at (787) 731-3633, extensions 1464 or 1471, and via email at [jalvelo@gnpr.pr.gov](mailto:jalvelo@gnpr.pr.gov).

VICTOR A. RODRIGUEZ  
Command Administrative  
Officer (CAO)



GOVERNMENT OF PUERTO RICO  
PUERTO RICO NATIONAL GUARD  
STATE GUARD COMMAND  
Tabonuco #2 GAM Tower  
San Patricio, Guaynabo, Puerto Rico 00968

PRSG-CAO

19 December 2025

MEMORANDO PARA REGISTRO

ASUNTO: Documentos requeridos para el Programa de Preparación para Soldados (SRP) y la Evaluación Periódica de Salud (PHA) para los Miembros Activos de la Guardia Nacional de Puerto Rico – Comando Estatal.

1. Se deben presentar los siguientes documentos durante el SRP/PHA:
  - a. FORMULARIO PRSG 2807-1 Historial Médico, (**Documentos completados digitalmente vía ([www.prsg.us](http://www.prsg.us))**).
  - b. FORMULARIO PRSG 93 Registro de Datos de Emergencia, (**Documentos completados digitalmente vía ([www.prsg.us](http://www.prsg.us))**).
  - c. Certificado de Antecedentes Penales. Se solicita en línea y llega el mismo día por correo electrónico. (<https://www.pr.gov/antecedentes-penales>). El documento impreso no debe tener más de 30 días de antigüedad.
  - d. Certificado de ASUME. Se solicita en línea y llega el mismo día por correo electrónico. (<https://app.asume.pr.gov/>). El documento impreso no debe tener más de 30 días de antigüedad.
  - e. Licencia de Conducir - Impresa por ambos lados, ampliada.
  - f. Identificación Militar (PRSG) - Impresa por ambos lados, ampliada.
  - g. Complete el Formulario de Beneficiario del Seguro de Vida FIGNA, según corresponda.
  - h. Completar los cuatro (4) Mandatory Briefings. (<http://www.prsg.us>).
  - i. Certificado BTC (IETC).
  - j. Certificados de Escuelas Militares / PME.
  - k. Certificados MEMS, según corresponda.
  - l. Cualquier Insignia (Badge) o Diploma obtenido durante el año.
2. Los soldados serán notificados a través de la Cadena de Mando sobre la fecha, hora y lugar donde deberán presentarse con los documentos requeridos.
3. Si tiene alguna duda o inquietud sobre este asunto, no dude en contactarnos.
4. El punto de contacto para este asunto es por teléfono al (787) 731-3633, extensiones 1464 o 1471, y por correo electrónico a [jalvelo@gnpr.pr.gov](mailto:jalvelo@gnpr.pr.gov).



VICTOR A. RODRIGUEZ  
Oficial Administrativo del  
Comando (CAO)

**PUERTO RICO STATE GUARD REPORT OF MEDICAL HISTORY**

(This information is for official and medically confidential use only and will not be released to unauthorized persons)

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.

PLEASE RETURN COMPLETED YOUR FORM TO YOUR PUERTO RICO STATE GUARD RECRUITER, SURGEON, OR DESIGNEE ONLY.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** The Health Insurance Portability and Accountability Act, HIPAA 104-191, Aug. 21, 1996. Military Code of Puerto Rico, Law Number 88 of August 8, 2023.

**PRINCIPAL PURPOSE(S):** The primary collection of this information is from individuals seeking to join the Puerto Rico State Guard Command. The information collected on this form is used to assist Puerto Rico State Guard physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. A notice of privacy practices can be viewed at: <https://www.salud.gov.pr/CMS/166>.

**ROUTINE USE(S):** The Blanket Routine: Uses apply to this collection. This form PRSG 2807-1 is also available at <http://prsg.us>

**DISCLOSURE:** Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Puerto Rico State Guard. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For a Puerto Rico State Guard member, failure to provide the information may result in the individual being placed in a non-deployable status.

**WARNING:** The information you have given constitutes an official statement. Provide false information is penalized by federal and Commonwealth of Puerto Rico laws.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. LAST FOUR SOCIAL SECURITY		3. TODAY'S DATE (DD/MM/YYYY)	
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)		5.a. EXAMINING LOCATION & ADDRESS CAMP SANTIAGO, SALINAS, PUERTO RICO			5.b. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5.c. TELEPHONE NUMBER (Include Area Code)		5.d. AGE:		5.e. HEIGHT:	
		5.f. WEIGHT:		5.g. BMI:	
X ALL APPLICABLE BOXES:					
6.a. SERVICE (MSC)	6.b. MILITARY STATUS	6.c. PURPOSE OF	EXAMINATION	7.a. POSITION Grade _____ Rank _____	
<input type="checkbox"/> Army <input type="checkbox"/> Air Group <input type="checkbox"/> Medical Command	<input type="checkbox"/> New Member <input type="checkbox"/> Active	<input type="checkbox"/> MEPS <input type="checkbox"/> PHA <input type="checkbox"/> Med.Board	<input type="checkbox"/> SRP <input type="checkbox"/> AT <input type="checkbox"/> Ret.Board	<input type="checkbox"/> Other (specify) _____	
8. CURRENT MEDICATIONS (Prescription and Over the Counter)			9. ALLERGIES (Including insect bites/stings, foods, medicine, or other substance)		

**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2**

HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO	12. CONTINUED	YES	NO
10.a. Tuberculosis		<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis		<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood		<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, etc.		<input type="radio"/>	<input type="radio"/>	i. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath		<input type="radio"/>	<input type="radio"/>	j. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
f. Bronchitis		<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, Knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing		<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler		<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night		<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis		<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever		<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds		<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble		<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter		<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble		<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble		<input type="radio"/>	<input type="radio"/>	g. Skin d (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye		<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worm contact lenses or glasses		<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid		<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)		<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow, or wrist (e.g., pain, dislocation, etc.)		<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis		<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem		<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling		<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe		<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	LAST FOUR SOCIAL SECURITY
<b>Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.</b>	
<b>HAVE YOU EVER HAD OR DO YOU NOW HAVE:</b> <b>YES</b> <b>NO</b> <b>YES</b> <b>NO</b>	
<b>15.a.</b> Dizziness or fainting spells <input type="radio"/> <input type="radio"/> b. Frequent or severe headache <input type="radio"/> <input type="radio"/> c. A head injury, memory loss or amnesia <input type="radio"/> <input type="radio"/> d. Paralysis <input type="radio"/> <input type="radio"/> e. Seizures, convulsions, epilepsy or fits <input type="radio"/> <input type="radio"/> f. Car, train, sea, or air sickness <input type="radio"/> <input type="radio"/> g. A period of unconsciousness or concussion <input type="radio"/> <input type="radio"/> h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> <input type="radio"/>	
<b>19.</b> Have you been refused employment or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. <input type="radio"/> <input type="radio"/> b. Inability to perform certain motions <input type="radio"/> <input type="radio"/> c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> <input type="radio"/> d. Other medical reasons ( <i>If yes, give reasons.</i> ) <input type="radio"/> <input type="radio"/>	
<b>20.</b> Have you ever been treated in an Emergency Room? <input type="radio"/> <input type="radio"/> <i>(If yes, for what?)</i>	
<b>21.</b> Have you ever been a patient in any type of hospital? ( <i>If yes, specify when, where, why, and more of doctor and complete address of hospital?</i> ) <input type="radio"/> <input type="radio"/>	
<b>22.</b> Have you ever had, or have you been advised to have any operation or surgery? ( <i>If yes, describe and give age at which occurred</i> ) <input type="radio"/> <input type="radio"/>	
<b>23.</b> Have you ever had any illness or injury other than those already noted? ( <i>If yes, specify when, where, and give details.</i> ) <input type="radio"/> <input type="radio"/>	
<b>24.</b> Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? ( <i>If yes, give complete address of doctor, hospital, clinic, and details.</i> ) <input type="radio"/> <input type="radio"/>	
<b>25.</b> Have you ever been rejected for military service for any reason? <input type="radio"/> <input type="radio"/> <i>(If yes, give date and reason for rejection.)</i>	
<b>26.</b> Have you ever been discharged from military service for any reason? ( <i>If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.</i> ) <input type="radio"/> <input type="radio"/>	
<b>27.</b> Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? ( <i>If yes, specify what kind, granted by whom, and what amount, when why.</i> ) <input type="radio"/> <input type="radio"/>	
<b>28.</b> Have you ever been denied life insurance? <input type="radio"/> <input type="radio"/>	
<b>29. EXPLANATION OF "YES" ANSWER(S)</b> ( <i>Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.</i> )	

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	LAST FOUR SOCIAL SECURITY																											
<p><b>30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA</b> (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important and record any significant findings here.)</p>																												
<p><b>COMMENTS</b></p>																												
<p><b>30. IMMUNIZATION HISTORY</b> (Please answer the following questions about your immunization history)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>a. Have you received an Influenza Vaccination (Flu Shot) this year (Are you current)?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>b. To your knowledge, have you received a Tetanus shot or vaccination called a DTaP, Tdap, or DTP in the last ten (10) years?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>c. Have you had a Hepatitis B series of 2, 3 or 4 shots or have a positive Hepatitis B surface antibody?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>d. Have you been diagnosed with having an immune deficiency disorder, a weakened immune system, have a family Member with an immune deficiency or are being treated for cancer or receiving chemotherapy?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>e. Have you received a COVID-19 Vaccination?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td colspan="3" style="text-align: center;"> <input type="checkbox"/> 1 Dosis    <input type="checkbox"/> 2 Dosis    <input type="checkbox"/> 3 Dosis    <input type="checkbox"/> Additional Dosis _____         </td> </tr> <tr> <td style="height: 40px;">31.a. TYPED OR PRINTED NAME OF PRSG Member (Last, First, Middle Initial)</td> <td style="height: 40px;">b. SIGNATURE OF MEMBER (SOILDER)</td> <td style="height: 40px;">c. DATE SIGNED (DD-MM-YYYY)</td> </tr> <tr> <td style="height: 40px;">d. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)</td> <td style="height: 40px;">e. SIGNATURE OF EXAMINER (PHYSICIAN)</td> <td style="height: 40px;">f. DATE SIGNED (DD-MM-YYYY)</td> </tr> </tbody> </table>			YES	NO	a. Have you received an Influenza Vaccination (Flu Shot) this year (Are you current)?	<input type="radio"/>	<input type="radio"/>	b. To your knowledge, have you received a Tetanus shot or vaccination called a DTaP, Tdap, or DTP in the last ten (10) years?	<input type="radio"/>	<input type="radio"/>	c. Have you had a Hepatitis B series of 2, 3 or 4 shots or have a positive Hepatitis B surface antibody?	<input type="radio"/>	<input type="radio"/>	d. Have you been diagnosed with having an immune deficiency disorder, a weakened immune system, have a family Member with an immune deficiency or are being treated for cancer or receiving chemotherapy?	<input type="radio"/>	<input type="radio"/>	e. Have you received a COVID-19 Vaccination?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 1 Dosis <input type="checkbox"/> 2 Dosis <input type="checkbox"/> 3 Dosis <input type="checkbox"/> Additional Dosis _____			31.a. TYPED OR PRINTED NAME OF PRSG Member (Last, First, Middle Initial)	b. SIGNATURE OF MEMBER (SOILDER)	c. DATE SIGNED (DD-MM-YYYY)	d. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	e. SIGNATURE OF EXAMINER (PHYSICIAN)	f. DATE SIGNED (DD-MM-YYYY)
	YES	NO																										
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# PUERTO RICO STATE GUARD RECORD OF EMERGENCY DATA

(This information is for official and confidential use only and will not be released to unauthorized persons)

## PRIVACY ACT STATEMENT

**AUTHORITY:** The Health Insurance Portability and Accountability Act, HIPAA, Aug. 21, 1996. Puerto Rico Military Code Century XXI, Law Number 88 of August 8, 2023.

**PRINCIPAL PURPOSES:** This form is used by military personnel of the Puerto Rico State Guard. For the Puerto Rico State Guard members, 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. The purpose of soliciting the last 4 SSN is to provide positive identification. All items may not be applicable.

**ROUTINE USES:** None. This PRSG form 93-is also available at <http://prsg.us/>

**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.

**WARNING:** The information you have given constitutes an official statement. Provide false information is penalized by federal and Commonwealth of Puerto Rico laws.

## 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.

**IMPORTANT: This form is divided into two sections: Section 1 - Emergency Contact Information.**

**Section 2 - Benefits Related Information. READ THE INSTRUCTIONS ON PAGES 3 AND 4 BEFORE COMPLETING THIS FORM.**

## SECTION 1 - EMERGENCY CONTACT INFORMATION

<b>1. NAME</b> (Last, First, Middle Initial)		<b>2. LAST 4 SOCIAL SECURITY</b>	
<b>3a. SERVICE CATEGORY</b> <input type="checkbox"/> ARMY <input type="checkbox"/> MEDICAL COMMAND <input type="checkbox"/> AIR GROUP <input type="checkbox"/> OTHER		<b>b. GRADE</b> <b>RANK</b>	
<b>4a. SPOUSE NAME</b> (If applicable) (Last, First, Middle Initial)  SINGLE   DIVORCED   WIDOWED		<b>b. ADDRESS</b> (Include ZIP Code) AND TELEPHONE NUMBER	
<b>5. CHILDREN</b> a. NAME (Last, First, Middle Initial)		<b>b. RELATIONSHIP</b>	<b>c. DATE OF BIRTH</b> (mm/dd/yyyy) <b>d. ADDRESS</b> (Include ZIP Code) AND TELEPHONE NUMBER
<b>6a. FATHER NAME</b> (Last, First, Middle Initial)		<b>b. ADDRESS</b> (Include ZIP Code) AND TELEPHONE NUMBER	
<b>7a. MOTHER NAME</b> (Last, First, Middle Initial)		<b>b. ADDRESS</b> (Include ZIP Code) AND TELEPHONE NUMBER	
<b>8a. DO NOT NOTIFY DUE TO ILL HEALTH</b>		<b>b. NOTIFY INSTEAD</b>	
<b>9a. DESIGNATED PERSON(S)</b> (Military only)		<b>b. ADDRESS</b> (Include ZIP Code) AND TELEPHONE NUMBER	
<b>10. OTHER EMERGENCY TELEPHONE NUMBER</b>			

**SECTION 2 - BENEFITS RELATED INFORMATION**

(This information is for official and confidential use only and will not be released to unauthorized persons)

<b>11a. BENEFICIARY(IES) FOR DEATH GRATUITY</b> <i>(Military only)</i>	<b>b. RELATIONSHIP</b>	<b>c. ADDRESS</b> <i>(Include ZIP Code) AND TELEPHONE NUMBER</i>	<b>d. PERCENTAGE</b>
<b>12a. BENEFICIARY(IES) FOR UNPAID PAY/ALLOWANCES</b> <i>(Military only)</i> <b>NAME AND RELATIONSHIP</b>	<b>b. ADDRESS</b> <i>(Include ZIP Code) AND TELEPHONE NUMBER</i>		<b>c. PERCENTAGE</b>
<b>13a. PERSON AUTHORIZED TO DIRECT DISPOSITION (PADD)</b> <i>(Military only)</i> <b>NAME AND RELATIONSHIP</b>	<b>b. ADDRESS</b> <i>(Include ZIP Code) AND TELEPHONE NUMBER</i>		
<b>14. CONTINUATION / REMARKS</b>			
<b>15. SIGNATURE OF SERVICE MEMBER</b> <i>(Include rank, rate, or grade if applicable)</i>	<b>16. SIGNATURE OF WITNESS</b> <i>(Include rank, rate, or grade as appropriate)</i>		<b>17. DATE SIGNED</b> <i>(mm/dd/yyyy)</i>

**Hoja de Beneficiarios para Seguro de Vida**

**FIGNA-SC-004- REV FEB2023**

<b>Seleccionar Estatus Actual</b>	Militar Activo GNPR	Retirado Recibiendo Anualidad	Otro (Especifique)

**A: Información Personal Del Asegurado Principal**

<b>Ambos Apellidos Y Nombre De Asegurado Principal</b>			
<b>DOD Number</b>			<b>Seg Social Completo</b>
<b>Fecha De Nacimiento</b>	Dia _____	Mes _____	Año _____
<b>Dirección Postal</b>			

**B: Información De Beneficiarios**

Ambos Apellidos Y Nombre Completo	Relación Con Solicitante	Fecha De Nacimiento Dia / Mes / Año	Seguro Social	Teléfono De Beneficiario	% Asignado

**C: Beneficiario Contingente:** Beneficiario en caso de que falten los beneficiarios ya designados y queda con el 100% del Seguro de Vida

Ambos Apellidos Y Nombre Completo	Relación Con Solicitante	Fecha De Nacimiento Dia / Mes / Año	Seguro Social	Teléfono De Beneficiario

**D: Certificación del Asegurado Principal**

Certifico que he leído lo señalado al dorso de este documento en la parte D y que conozco los requisitos para estar cubierto por el Seguro de vida que el Fideicomiso Institucional de la Guardia Nacional de Puerto Rico (FIGNA) ofrece y me comprometo a orientar los beneficiarios designados en este documento y que conozcan que el mismo no es vitalicio y pierde validez al dejar de cumplir con lo establecido en el Reglamento para el Seguro de Vida y Funeral de FIGNA.

Firma del Asegurado Principal

Fecha

<b>E: Uso exclusivo de FIGNA</b>	Firma del Técnico de Beneficios		Fecha de Recibido	
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- **A: Información Personal Del Asegurado Principal**

El Asegurado Principal debe completar todos los campos que se solicitan. El DOD number solamente aplica a los que tienen la identificación federal otorgada por el Departamento de la Defensa.

- **B: Información De Beneficiarios**

Los beneficiarios serán designados por el asegurado titular. La suma de los % designados deberán corresponder al 100%. El asegurado titular podrá cambiar de beneficiarios cuando lo estime conveniente, enviando el nuevo formulario a la compañía.

- **C: Beneficiario Contingente:**

Beneficiario en caso de que falten los beneficiarios ya designados y queda con el 100% del Seguro de Vida

- **D: Certificación del Asegurado Principal**

Debe leer con detenimiento y si esta de acuerdo, firmar y anotar la fecha

- El documento pierde validez cuando:

- ✓ El Militar activo de la GNPR, no estaba pagando FIGNA al momento de su fallecimiento.
- ✓ El Militar se retira de la GNPR y no esta recibiendo el incentivo de Anualidad para Retirados.
- ✓ Los Retirados recibiendo Anualidad cumplen los 60 años de edad.
- ✓ El miembro del Comando Estatal no estaba activo cumpliendo los compromisos.
- ✓ El miembro del Comando Estatal tiene 60 o más años de edad

- **E: Uso exclusivo de FIGNA**