

ADMINISTRATIVE REMARKS

Entry Type: Reserve Incapacitation Benefits (RIB-4)
 Reference: Reserve Policy Manual, COMDTINST M1001.28 (Series)
 Responsible Level: Unit
 Entry: _____

1. _____ Counseled this date regarding my decision to be released from Active Duty prior to resolution of my
 (Date) Line of Duty (LOD) medical condition.
2. _____ I understand that if I consent to remain on Active Duty for medical care, my care will be coordinated
 (Initials) through a Military Treatment Facility (MTF).
3. _____ I understand that while on orders greater than 30 days, TRICARE is available for me and my family.
 (Initials)
4. _____ I understand that while on Active Duty I receive pay and allowances to the same extent permitted by
 (Initials) law for regular component members.
5. _____ I understand that I may be eligible to remain on Active Duty until I am Fit for Duty or separated/retired
 (Initials) by the Disability Evaluation System (PDES).
6. _____ I understand all of the above and I am requesting to be released from Active Duty.
 (Initials)
7. _____ I understand that I may request a Notice of Eligibility (NOE) for continued medical care to be
 (Initials) coordinated by a MTF. If authorized, the NOE will only cover medical care for a specific LOD condition.
8. _____ I understand that if a (NOE) is authorized, I may be eligible for incapacitation pay and that claims are paid
 (Initials) 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.
9. _____ I understand that when I am released from Active Duty my family and I may no longer be eligible for
 (Initials) TRICARE benefits. (This does not apply to those personnel with Transitional Assistance Management Program (TAMP) or TRICARE Reserve Select (TRS) benefits.
10. _____ I certify that this release from Active Duty is voluntary and I have not been coerced into voluntary
 (Initials) separation. I have been thoroughly counseled on this voluntary release and all my concerns have been addressed to my satisfaction.

 (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	6. PAGE 7	