OMB Control No. 2900-0179
Respondent Burden: 30 Minutes
Expiration Date: 10/31/2027

Department of Veterans Affairs

APPLICATION FOR CHANGE OF PERMANENT PLAN (MEDICAL)

(CHANGE TO A POLICY WITH A LOWER RESERVE VALUE)

(For Use of VA Index)

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses identified in VA system of records, 36VA29, Veterans and Uniformed Services Personnel of U.S. Government Life Insurance - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The responses you submit are considered confidential (38 USC 5701).

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0179, and it expires 10/31/2027. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, 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 and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0179 in any correspondence. Do not send your completed VA Form 29-1549 to this email address.

INSTRUCTIONS

This form is used to change a permanent plan of Insurance to another permanent plan with a lower reserve value.
The difference between the reserve of the two plans may be applied to a policy loan, applied to future premiums, or refunded to you in cash.
REQUIREMENT: You must be in good health to change to a plan with a lower reserve value. Please complete all the health questions on the back of this form.
The beneficiary and/or optional settlement under the new policy will remain the same as under the old policy. If a change is desired, submit VA Form 29-336, Designation of Beneficiary - Government Life Insurance.
It is not possible to change from a permanent plan to Term Insurance. Call our toll-free number for information on the available plans.
The fastest and most secure way for insureds and beneficiaries to send the application to VA Insurance is to use the document upload service at https://insurance.va.gov/home/IDU. Or you may complete and return this form to the following address:

Department of Veterans Affairs
Regional Office and Insurance Center (COP)
P. O. Box 7208
Philadelphia, PA 19101

PART I - STATEMENT OF APPLICATION

1. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED	2. INSURANCE POLICY NUMBER *(If more than one policy, please complete a separate form for each policy number)*
3. MAILING ADDRESS	

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER *(If any)*	6. DAYTIME TELEPHONE NUMBER

7. POLICY NUMBER	8. AMOUNT OF INSURANCE APPLIED FOR	9. PLAN OF INSURANCE APPLIED FOR	10. DO YOU WISH TO CONTINUE OR ADD THE TOTAL DISABILITY INCOME PROVISION? ☐ YES ☐ NO

11. DISPOSITION OF RESERVE CREDIT
☐ PAY FUTURE PREMIUMS ☐ APPLY TO INDEBTEDNESS ☐ PAY IN CASH

12. METHOD OF PREMIUM PAYMENT
☐ DIRECT PAYMENT TO VA *(Complete Item 13)* ☐ MONTHLY ALLOTMENT FROM SERVICE PAY
☐ MONTHLY DEDUCTION FROM VA BENEFIT CHECK ☐ MONTHLY DEDUCTION FROM YOUR CHECKING ACCOUNT

13. MODE OF PREMIUM PAYMENT
☐ MONTHLY ☐ ANNUALLY

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE CALL TOLL FREE 1-800-669-8477.

PART II - EMPLOYMENT AND HEALTH INFORMATION

The purpose of questions listed below is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.

It may be necessary to ask for a physical examination in connection with this application.

Please answer every question, date and sign this application.

NOTE: Complete the following employment questions. If additional space is needed, attach a separate sheet of paper.

1A. ARE YOU NOW WORKING? ☐ YES ☐ NO 1B. DO YOU WORK FULL TIME? ☐ YES ☐ NO	1C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING: *(Check all that apply)*

	YES	NO		YES	NO
2. DISEASE OF THE HEART OR ARTERIES; CHEST PAIN?	☐	☐	14. ANY DISEASE OF THE PROSTATE OR TESTES IF A MALE; UTERUS, OVARIES OR BREAST IF A FEMALE?	☐	☐
3. HIGH BLOOD PRESSURE?	☐	☐	15. DO YOU USE OR HAVE YOU BEEN TREATED FOR THE USE OF ALCOHOL OR ANY HABIT FORMING DRUG?	☐	☐
4. CANCER, TUMOR OR POLYP?	☐	☐			
5. LUNG DISEASE?	☐	☐	16. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?	☐	☐
6. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?	☐	☐	17. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?	☐	☐
7. EMOTIONAL OR MENTAL DISORDER?	☐	☐	18. DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?	☐	☐
8. DISEASE OF THE BLOOD?	☐	☐	19. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?	☐	☐
9. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?	☐	☐			
10. DIABETES?	☐	☐	20. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED APPROVED AT SUB-STANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?	☐	☐
11. ARTHRITIS, PARALYSIS, OR DISEASE, OR DEFORMITY OF THE BONES, MUSCLES, OR JOINTS?	☐	☐			
12. DISEASE OR ULCER OF STOMACH, INTESTINES OR RECTUM?	☐	☐	21. HEIGHT: _____ FEET _____ INCHES		
13. ANY DISEASE OF THE URINARY TRACT, SUGAR, ALBUMIN, OR BLOOD IN URINE?	☐	☐	22. WEIGHT: _____ POUNDS		

23. REMARKS *(Give complete details to "YES" answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected or nonservice-connected. If additional space is needed, attach a separate sheet of paper)*

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to VA any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise VA of any change of health condition arising after the signing and prior to delivery of this form to VA.

24A. SIGNATURE	24B. DATE *(MM/DD/YYYY)*