



CLAIM FOR ONE SUM PAYMENT GOVERNMENT LIFE INSURANCE

1. INSURANCE FILE
2. INSURANCE POLICY
3. NET AMOUNT OF INSURANCE
4. FIRST, MIDDLE, LAST NAME OF INSURED VETERAN
5. BENEFICIARY'S SHARE (<i>Fraction</i>)

INSTRUCTIONS

To claim the proceeds of a Government Life Insurance policy, please complete, sign and return this form.

IF YOU ARE INTERESTED IN RECEIVING THE PROCEEDS BY DIRECT DEPOSIT, PLEASE FILL OUT THE INFORMATION BELOW.

WE ALSO NEED A PHOTOCOPY OF THE VETERAN'S DEATH CERTIFICATE OR A STATEMENT FROM THE ATTENDING PHYSICIAN SHOWING DATE AND CAUSE OF DEATH. ONLY ONE CERTIFICATE OR STATEMENT IS REQUIRED FOR OUR RECORDS.

If the beneficiary is a minor or incompetent, the person having custody of the beneficiary should complete the form and give his/her address in Item 10. If you are signing as the guardian or attorney-in-fact, please include a copy of the court appointment or power of attorney.

Send this completed form to: **Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7208
Philadelphia, PA 19101**

NOTE: If you prefer, instead of mailing this form, it may be FAXED to: 1-888-748-5822.

6. FIRST, MIDDLE, LAST NAME OF BENEFICIARY (<i>Please print</i>)	7. RELATIONSHIP TO INSURED
8. BENEFICIARY'S DATE OF BIRTH	9. BENEFICIARY'S SOCIAL SECURITY NUMBER
10. ADDRESS OF BENEFICIARY (<i>Address where check is to be mailed</i>) (<i>Please print</i>)	11. BENEFICIARY'S DAYTIME TELEPHONE
	12. DATE OF DEATH OF INSURED
CERTIFICATION: I certify that the above entries are true and correct to the best of my knowledge and belief.	
13. SIGNATURE OF BENEFICIARY, FIDUCIARY OR GUARDIAN	14. DATE

TO BE COMPLETED BY BENEFICIARY IF DIRECT DEPOSIT IS DESIRED

A. NAME OF FINANCIAL INSTITUTION	B. ROUTING TRANSIT NUMBER
C. ADDRESS OF FINANCIAL INSTITUTION	D. DEPOSITOR ACCOUNT NUMBER
E. TELEPHONE NUMBER OF FINANCIAL INSTITUTION ()	F. TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

PRIVACY ACT NOTICE: No proceeds may be paid unless a completed claim form has been received (38 U.S.C. 1917 and 1952). The information provided on a voluntary basis will be used by VA employees and your authorized representatives in the maintenance of Government Insurance programs. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, published in the Federal Register.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 6 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. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

IF YOU HAVE QUESTIONS ABOUT THIS FORM, PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477.