OMB Control No. 2900-0128
Respondent Burden: 12 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

NOTICE OF LAPSE
GOVERNMENT LIFE INSURANCE

1. INSURANCE FILE NUMBER	2. POLICY NO. *(Including letter prefix)*	3. DATE OF LAPSE *(MM/DD/YYYY)*	4. DATE MAILED BY VA *(MM/DD/YYYY)*
F			

ADDRESS OF INSURED

•

•

5. AMOUNT OF INSURANCE
$

6. DATE OF LAST TIMELY PAYMENT *(MM/DD/YYYY)*

7. AMOUNT OF LAST TIMELY PAYMENT
$

8. AMOUNT NEEDED TO REINSTATE

A	PREMIUMS DUE	$
B	LESS OVERAGE	-
C	PLUS SHORTAGE	+
D	TOTAL AMOUNT DUE	$

Your insurance lapsed on the date shown. You may reinstate your protection now by following the instructions in the paragraphs checked below.

☐ Complete the application on the back of this form and return it at once with a payment for the total amount due.

☐ Return this form at once with a payment for the total amount due. You do not have to complete the application.

☐ If you submit your application on or after _____ *(MM/DD/YYYY)*, add to the total amount due one additional premium of $ _____ for each month of delay. If you delay reinstatement more than six months from the date of lapse, interest will be charged on all premiums from date of lapse.

☐ The current term period of your policy ends _____ *(MM/DD/YYYY)*. If you reinstate after that date, the amount required to reinstate is $ _____ based on the renewal premium of $ _____ monthly.

☐ If you reinstate on or before _____ *(MM/DD/YYYY)*, evidence that your health is as good on the date of the application as it was at the end of the grace period is acceptable. Otherwise, a VA Form 29-352, Application For Reinstatement, will be required.

☐ Unless you meet reinstatement requirements on or before _____ *(MM/DD/YYYY)* you will have lost all rights to reinstate this insurance.

☐ The payment sent on _____ *(MM/DD/YYYY)* could not be used to prevent lapse. This payment is included in Item 8B.

☐ Additional Instructions:

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

FROM	Department of Veterans Affairs Regional Office and Insurance Center P.O. Box 42954 Philadelphia, PA 19101

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APPLICATION FOR REINSTATEMENT

Privacy Act Notice: 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 38, Code of Federal Regulations 1.576 for routine uses (i.e., to reinstate lapsed government life insurance) as identified in the VA system of records, 36VA29, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records-VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701).

Respondent Burden: We need this information to determine your eligibility for reinstatement (38 U.S.C. 722). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 12 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

BE SURE TO INSERT ALL INFORMATION - DATE - SIGN AND MAIL IMMEDIATELY WITH THE TOTAL AMOUNT.

1. AMOUNT OF INSURANCE TO BE REINSTATED	2. AMOUNT OF TOTAL DISABILITY INCOME PROVISION TO BE REINSTATED	3. AMOUNT SENT WITH THIS APPLICATION	4. SOCIAL SECURITY NUMBER

CERTIFICATION OF HEALTH

5A. I am applying for reinstatement of my insurance in the amount shown above. As a condition to the reinstatement of this insurance, I certify that to the best of my knowledge and belief, I am in as good health now as I was on the last day of the grace period (31 days after the date of lapse).

☐ YES ☐ NO *(If "No," please complete Item 5B)*

5B. Please describe any illness, disease, injury or medical treatment with dates, which have occurred since the date of lapse.

I UNDERSTAND THAT:

A. If my application is approved, the last named beneficiary(ies) and selection of optional settlement(s) on policy(ies) reinstated, will continue in effect unless the Department of Veterans Affairs receives a request for a change in writing over my signature. (VA Form 29-336 should be used to make any changes.)

B. STATEMENTS MADE BY ME IN THIS APPLICATION ARE RELIED UPON. ANY DECEPTION OR FALSE STATEMENT EITHER BY INFERENCE, OMISSION, OR OTHERWISE, MAY CAUSE CANCELLATION OF THE INSURANCE OR REFUSAL TO PAY A CLAIM. IN EITHER CASE, PREMIUMS MAY NOT BE RETURNED.

C. I must let the Department of Veterans Affairs know of any change in my health beginning after the date I sign and before the date I send this form to the Department of Veterans Affairs.

IMPORTANT: This form must be fully COMPLETED, SIGNED and sent IMMEDIATELY to the Department of Veterans Affairs. Checks and money orders should be made payable to the Department of Veterans Affairs.

The fastest and most secure way to send documents to VA Insurance is to use our document upload service at https://insurance.va.gov/home/IDU.

OR MAIL THE COMPLETED FORM TO:
VAROIC
P.O. Box 42954
Philadelphia, PA 19101

Online Bill Pay - Pay your premium or loan payment through your preferred banking institution online Bill Pay feature. Select **"VA LIFE INSURANCE"** as the Payee and enter your **Insurance File Number** as the Account Number.

VA Collection Address:
P.O. Box 4019
Portland, OR 97208-4019

6. MAILING ADDRESS *(Please complete only if your address shown on the front is not correct)*	7. TELEPHONE NUMBER *(Include Area Code)*
8. SIGNATURE OF POLICYHOLDER *(Sign in ink. Do not print. This certification must be signed and dated)*	9. DATE OF SIGNATURE *(MM/DD/YYYY)*

PENALTY - The law provides whoever makes any statement of material fact knowing it to be false shall be punished by fine or imprisonment or both.