



APPLICATION FOR SERVICE-DISABLED INSURANCE

PRIVACY ACT INFORMATION: No insurance may be granted unless a completed application has been received (38 U.S.C. 722). The information provided on a voluntary basis, will be used by VA employees and your authorized representative 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: Public reporting burden for this collection of information is estimated to average 40 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Clearance Officer (723), 810 Vermont Ave., NW, Washington, DC 20420; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Paperwork Reduction Project (2900-0068), Washington, DC 20503.

You may qualify for up to \$10,000 coverage at regular premium rates even if you have been rejected for insurance by a commercial company or were offered a policy at high premiums because of a disability.

Before you decide to apply for this coverage we encourage you to be a smart shopper and compare our premium rates to a few other insurance companies. After all, life insurance is an important decision and we want you to get the best deal possible for your money. If your disability is not serious, a commercial company may be able to offer you a better deal. Compare their premium rates to the Government Life Insurance rates in VA pamphlet 29-9.

When considering the cost of this coverage, remember that if you become totally disabled and unable to work for six or more months, you do not have to pay premiums on your Government Life Insurance policy. This benefit is added at no extra cost. Most commercial life insurance companies add an additional charge for this benefit.

Do not delay when comparing costs; you have only two years from the date VA notified you of your service-connected disability to apply for our coverage (this time period is reduced to one year if the date VA notified of your service-connected disability was prior to September 1, 1991). If you decide to apply, fill out the application below.

If you have any questions on Government Life Insurance, just call our toll-free number, 1-800-669-8477. We will be on the line ready to help with your questions.

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS APPLICATION

1. NAME AND MAILING ADDRESS FOR INSURANCE PURPOSES				
FIRST, MIDDLE, LAST NAME				
NUMBER AND STREET OR RURAL ROUTE				
CITY, STATE AND ZIP CODE				
2. BENEFICIARY DESIGNATION AND SELECTION OF OPTIONAL SETTLEMENT				
COMPLETE NAME AND ADDRESS OF EACH PRINCIPAL AND CONTINGENT BENEFICIARY <i>(If a married woman, enter her own first and middle names. For example, Mary Rose Smith, not Mrs. John Smith.)</i>	BENEFICIARY'S SOCIAL SECURITY NO. <i>(If known, See Important information on reverse)</i>	RELATIONSHIP OF EACH TO THE INSURED	AMOUNT TO EACH <i>Fractions such as 1/2, 2/3, or 3/4</i>	OPTION FOR EACH <i>(1, 2, 3, or 4)</i>
				1
				1
				1
OR TO SURVIVORS				1
CONTINGENT <i>(Person(s) who get the proceeds if the principal beneficiary(ies) die before the insured. If none, write "NONE".)</i>				
				1
				1
				1
				1
OR TO SURVIVORS				1
DO NOT WRITE IN THE SPACE BELOW - FOR VA USE ONLY				
ENTER BY VA	SIGNATURE OF VA INSURANCE OFFICIAL	DATE RECORDED		

EVERY QUESTION MUST BE ANSWERED, BE SURE TO SIGN ON THIS SIDE

3. VA CLAIM NUMBER <i>(If any)</i>	4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH <i>(Month, Day, Year)</i>	6. DAYTIME TELEPHONE NUMBER <i>(Include Area Code)</i> ()
7. ENTER AMOUNT, PLAN AND PREMIUM OF THE INSURANCE FOR WHICH YOU ARE APPLYING			
A. AMOUNT OF INSURANCE	B. PLAN OF INSURANCE	C. MONTHLY PREMIUM	
8. CHECK THE METHOD SHOWING HOW YOU WISH TO PAY FOR THIS INSURANCE			
<input type="checkbox"/> A. I WANT TO PAY PREMIUMS BY A MONTHLY DEDUCTION FROM MY VA COMPENSATION OR PENSION <i>(we will start the deduction for you if the insurance is approved)</i>			
<input type="checkbox"/> B. I WANT TO PAY PREMIUMS BY A MONTHLY ALLOTMENT FROM MY MILITARY SERVICE/RETIREMENT PAY <i>(we will start the allotment for you if the insurance is approved)</i>			
<input type="checkbox"/> C. I WANT VA TO AUTOMATICALLY WITHDRAW THE PREMIUM EACH MONTH FROM MY BANK ACCOUNT (VA MATIC) <i>(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION - We will contact you for additional information needed to start the withdrawal)</i>			
<input type="checkbox"/> D. I WILL SEND PREMIUMS DIRECTLY TO VA AS FOLLOWS: <i>(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION)</i>			
<input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> ANNUALLY			
9A. ARE YOU NOW WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	9B. DO YOU WORK FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO	9C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY	
10A. ARE YOU NOW HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," for what condition(s)?)</i>		10B. NAME AND ADDRESS OF HOSPITAL	
11. HAVE YOU AT ANY TIME REQUIRED ANY FORM OF TREATMENT OR REHABILITATION OR BEEN FORCED TO DISCONTINUE EMPLOYMENT AS A RESULT OF THE USE OF ALCOHOL OR DRUGS, INCLUDING MARIJUANA, SEDATIVES, STIMULANTS, BARBITURATES, ETC.? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," give date(s) and type of treatment(s))</i>			
12. HAVE YOU HAD ANY OF THE FOLLOWING:	YES	NO	13. IF YOUR ANSWER TO ANY PART OF ITEM 12 IS "YES" GIVES DATES, DURATION, AND OTHER DETAILS <i>(If more space is needed, attach a separate sheet)</i>
A. DIZZY OR FAINTING SPELLS?			
B. TUBERCULOSIS, BRONCHITIS, OR PLEURISY?			
C. MENTAL OR NERVOUS DISORDERS?			
D. BLOOD DISORDER?			
E. HEART CONDITION?			
F. CANCER, TUMOR, OR GOITER?			
G. ULCERS OR GALLSTONES?			
H. DIABETES?			
I. EPILEPSY OR PARALYSIS?			
J. HIGH BLOOD PRESSURE?			14. HAVE YOU HAD ANY OTHER PHYSICAL DEFECT OR DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "YES," explain)</i>
15B. HEIGHT FEET INCHES	15C. HAS YOUR WEIGHT CHANGED MORE THAN TEN POUNDS DURING THE PAST TWO YEARS? <i>(If "YES," give complete details including amount gained or lost and length of time present weight maintained)</i>		
15B. WEIGHT LBS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
CERTIFICATION: I have reviewed all of my answers above and certify that they are true and correct to the best of my knowledge and belief.			
16A. SIGNATURE OF APPLICANT <i>(Do not print; sign in ink)</i>			16B. DATE

IMPORTANT INFORMATION

This form may be used by any person released from active service in the Armed Forces on or after April 25, 1951, who has a service-connected disability and meets good health standards as established by the Secretary. The application for insurance and payment of the required premium must be made within two years from the date of notice by the Department of Veterans Affairs (VA) that any disabilities are determined to be service-connected (this time period is reduced to one year if the date VA notified of your service-connected disability was prior to September 1, 1991). Only the veteran, or COURT-APPOINTED guardian, or VA recognized fiduciary, can apply for this insurance. DO NOT DELAY SENDING THIS DESIGNATION if you do not have a beneficiary's Social Security Number handy. Your application and designation are still valid even if you do not know the Social Security Number, so send this form promptly upon completion. Having the beneficiary's Social Security Number will help us locate the beneficiary.

After completion of this application, submit it IMMEDIATELY to:

**DEPARTMENT OF VETERANS AFFAIRS
REGIONAL OFFICE AND INSURANCE CENTER (RH)
P.O. BOX 7208
PHILADELPHIA, PA 19101**

If you have any questions about this insurance, please call toll-free at 1-800-669-8477.