

FILE NUMBER:

Congress has approved new legislation which allows the Department of Veterans Affairs (VA) to offer an additional \$20,000 of Supplemental Service Disabled (RH) insurance to **totally disabled RH** policyholders. This new insurance is similar to the RH insurance you have today and may be added to your existing coverage. This Supplemental insurance **does not** provide for waiver of premiums due to total disability.

You may select from any of the nine plans of RH insurance. The premiums for the Supplemental RH insurance are determined by your age and plan of insurance you select. Rates are based on the standard RH premium rate schedules. The enclosed VA pamphlet (29-9) contains a description of the available plans and premium rates. To be eligible for this insurance you must be under 65 years of age and be totally disabled. If you meet these requirements and wish to apply, please complete this application and return it to: **Department of Veterans Affairs, Regional Office and Insurance Center - SRH, P.O. Box 7208, Philadelphia, PA 19101**. This application must be submitted before November 1, 1993, or before your 65th birthday whichever occurs first.

If you have any additional questions concerning your Government Life Insurance, just call our toll-free number, 1-(800)-669-8477.

Sincerely yours,

OMB Approved No. 2900-0539

	Respondent Burden: 20 Minutes					
Department of Veterans Affairs	APPLICATION FOR SUPPLEMENTAL SERVICE DISABLED VETERANS (RH) LIFE INSURANCE					
NOTE: Please type or print in ink and complete both sides of this form. Sign and date on reverse.						
1. ARE YOU NOW WORKING?	2. ARE YOU TOTALLY DISABLED?					
□ YES □ NO	☐ YES ☐ NO					
3. DATE DISABILITY PREVENTED EMPLOYMENT						
4. ENTER THE AMOUNT, PLAN AND PREMIUM OF THE INSURANCE FOR WHICH YOU ARE APPLYING (See VA Pamphlet 29-9)						
AMOUNT OF INSURANCE REQUESTED	PLAN OF INSURANCE	MONTHLY PREMIUM AMOUNT				
5. CHECK THE METHOD SHOWING HOW YOU WISH TO PAY THE PREMIUMS FOR THIS INSURANCE (Check one)						
BY A MONTHLY DEDUCTION FROM VA COMPENSATION OR PENSION (We will start the deduction for you if the insurance is approved)						
BY A MONTHLY ALLOTMENT FROM MY MILITARY SERVICE/RETIREMENT PAY (We will start this allotment for you if the insur						
BY AUTOMATIC MONTHLY WITHDRAWALS FROM MY BANK ACCOUNT (VA MATIC) (SEND YOUR FRIST PAYMENT WITH THIS APPLICATION)(We will contact you for the additional information needed to start the withdrawal)						
UVILL SEND PREMIUMS DIRECTLY TO VA AS (SEND YOUR FIRST PAYMENT WITH THIS AF	S FOLLOWS: MONTHLY QUARTER	LY SEMI-ANNUALLY ANNUALLY				
VA FORM 20 0400	, <u> </u>					

VA FORM **29-0190** JUL 2004

PRIVACY ACT INFORMATION: No insurance may be granted unless a completed application has been received (38 U.S.C. 1922). 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 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 20 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 comments.

	,	11-800-827-1000 for mailing infor		ind Comments.		
	6. BENEF	FICIARY DESIGNATION	_			
SHOW FUL	L NAME AND ADDRESS OF EACH PRINCIPAL AND CONTINGENT BENEFICIARY	BENEFICIARY'S SOCIAL SECURITY NO. (If Known)	RELATIONSHIP TO INSURED	SHARE TO EACH (Use fractions such as 1/2,2/3 or all)	OPTION FOR EACH 1,2,3 OR 4	
	PRINCIPAL					
					1	
					1	
					1	
					1	
	OR TO SURVIVOR(S)				1	
(Person(s) who rece	CONTINGENT eives proceeds if all of the Principal Beneficiaries e the insured.) (If none, write "NONE")	die				
					1	
					1	
					1	
					1	
	OR TO SURVIVOR(S)				1	
7. REMARKS (Include any additional information which will clarify your intent regarding the payment of your insurance. Also, list the policy		8. YOUR SOCIAL SECURITY NUMBER				
number of any policy on	which the beneficiary is not to be changed)	9. DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE)				
		9. DATTIME TELEFTIONE N	IONIBER (INCLUDE AI	NEA CODE)		
all Government Life	is change cancels all prior Beneficiary and Option e Insurance policies under the above file number.	n selections; and unless indicate.	ed in item 7, Remar	ks, this change applie	es to	
10. SIGNATURE OF INSURED (Do not print)			11. DA ⁻	11. DATE		
	IMPORTA	NT INFORMATION	<u> </u>			
	n is still valid even if you do not know the ficiary's Social Security Number will help			plication right awa	ıy.	
If yo	ou have any questions concerning design	nating a beneficiary, call u	us toll free at 1-8	800-669-8477		
·	DO NOT WRITE IN THE S	DACE BELOW FOR	VA LICE ON	IV		
ENTERED DVVV						
ENTERED BY VA	SIGNATURE OF VA INSURANCE OFFICIAL	DATE RECOR	DED POLIC	Y NUMBER ASSIGNED		
			RH-			