Department of Veterans Affairs

IN REPLY REFER TO:

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 similiar 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)*

☐ I WILL SEND PREMIUMS DIRECTLY TO VA AS FOLLOWS: ☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY
(SEND YOUR FIRST PAYMENT WITH THIS APPLICATION)

VA FORM
JUL 2004 **29-0190**

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.

6. BENEFICIARY DESIGNATION

SHOW FULL 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
CONTINGENT *(Person(s) who receives proceeds if all of the Principal Beneficiaries die before the insured.)* (If none, write "NONE")				
				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 number of any policy on which the beneficiary is not to be changed)*

8. YOUR SOCIAL SECURITY NUMBER

9. DAYTIME TELEPHONE NUMBER *(INCLUDE AREA CODE)*

I understand that this change cancels all prior Beneficiary and Option selections; and unless indicated in item 7, Remarks, this change applies to all Government Life Insurance policies under the above file number.

10. SIGNATURE OF INSURED *(Do not print)*

11. DATE

IMPORTANT INFORMATION

Your designation is still valid even if you do not know the Social Security Number, so send this application right away. Having the beneficiary's Social Security Number will help us locate the beneficiary.

If you have any questions concerning designating a beneficiary, call us toll free at 1-800-669-8477

DO NOT WRITE IN THE SPACE BELOW - FOR VA USE ONLY

ENTERED BY VA	SIGNATURE OF VA INSURANCE OFFICIAL	DATE RECORDED	POLICY NUMBER ASSIGNED
			RH-