OMB Control No. 2900-0179 Respondent Burden: 30 minutes

(For Use of VA Index)

Department of Veterans Affairs

APPLICATION FOR CHANGE OF PERMANENT PLAN (MEDICAL)

(CHANGE TO A POLICY WITH A LOWER RESERVE VALUE)

PRIVACY ACT INFORMATION: 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 5, Code of Federal Regulations 1.526 for rountine uses identified in VA system of records, 36VA00, Veterans and Armed Forces Personnel U. S. Government Life Insurance Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The repsonses you submit are considered confidential (38 USC 5701).

RESPONDENT BURDEN: We need this information to verify your eligibility to change your permanent plan (38 U.S.C. 5902). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 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.whitehouse.gov/library/omb/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send your suggestions or comments about this form.

INSTRUCTIONS

This form is used to change a permanent plan of Insurance to another permanent plan with a lower reserve value.

The difference between the reserve of the two plans may be applied to a policy loan, applied to future premiums, or refunded to you in cash.

REQUIREMENT: You must be in good health to change to a plan with a lower reserve value. Please complete all the health questions on the back of this form.

The beneficiary and/or optional settlement under the new policy will remain the same as under the old policy. If a change is desired, submit VA Form 29-336, Designation of Beneficiary - Government Life Insurance.

It is not possible to change from a permanent plan to Term Insurance. Call our toll-free number for information on the available plans.

pians.							
Complete and return this form to the following address:	Department of Veterans Regional Office and Insu P. O. Box 7208 Philadelphia, PA 19101						
PART I - STATEMENT OF APPLICATION							
1. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED		2. INSURANCE FILE NUMBER (Include letter prefix)					
3. MAILING ADDRESS		1					
4. SOCIAL SECURITY NUMBER 5. VA FILE NUM	MBER (If any)	6. DAYTIME TELEPHONE NUMBER					
Z DOLLOVANIANDED	lo BLAN OF INCUBANCE	40. DO VOLUMBULTO OCUTANUS OD ADD TUE					
7. POLICY NUMBER 8. AMOUNT OF INSURANCE APPLIED FOR	9. PLAN OF INSURANCE APPLIED FOR	10. DO YOU WISH TO CONTINUE OR ADD THE TOTAL DISABILITY INCOME PROVISION					
\$		☐YES ☐NO					
11. DISPOSITION OF RESERVE CREDIT							
THE SIGN OF THESE TYPE ONE STITLE							
PAY FUTURE PREMIUMS APPLY TO INDEBTE	EDNESS PAY IN CAS	н					
12. METHOD OF PREMIUM PAYMENT							
DIRECT PAYMENT TO VA (Complete Item 13)	MONTHLY ALLOTMEN	NT FROM SERVICE PAY					
MONTHLY DEDUCTION FROM VA BENEFIT CHECK	N FROM YOUR CHECKING ACCOUNT						
13. MODE OF PREMIUM PAYMENT							
MONTHLY QUARTERLY SEMI-ANNUALLY	ANNUALLY						
IF YOU HAVE ANY QUESTIONS ABOUT							
VA FORM EXISTING STO WILL BE USED	CKS OF VA FORM 29-1549, JUL 200	01,					

PART II - EMPLOYMENT AND HEALTH INFORMATION								
The purpose of questions listed below is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.								
It may be necessary to ask for a physical examination in connection with this application.								
Please answer every question, date and sign this application.								
NOTE: Complete the following employment questions. If additional space is needed, attach a separate sheet of paper. IC. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY								
A. ARE YOU NOW WORKING? 1C. IF NOT WORKING YES NO	VG OR W	VORK	ING PART-TIME, EXPLAIN WHY					
B. DO YOU WORK FULL TIME?								
□YES □NO								
HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING: (Check all that apply)								
	YES		14. ANY DISEASE OF THE PROSTATE OR	YES	NO			
CHEST PAIN?			TESTES IF A MALE; UTERUS, OVARIES OR BREAST IF A FEMALE?					
3. HIGH BLOOD PRESSURE?			15. DO YOU USE OR HAVE YOU BEEN					
	++	\dashv	TREATED FOR THE USE OF ALCOHOL OR					
4. CANCER, TUMOR OR POLYP?		ŀ	ANY HABIT FORMING DRUG? 16. WITHIN THE PAST 5 YEARS, HAVE YOU	\vdash				
5. LUNG DISEASE?			BEEN TREATED BY A PHYSICIAN?					
6. EPILEPSY, UNCONSCIOUSNESS, DIZZI- NESS OR IMPAIRMENT OF NERVOUS SYSTEM?			17. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?					
7. EMOTIONAL OR MENTAL DISORDER?			18. DO YOU HAVE ANY SERVICE - CONNECTED DISABILITIES?					
8. DISEASE OF THE BLOOD?			19. HAVE YOU EVER APPLIED FOR DISABIL- ITY COMPENSATION OR PENSION?					
9. TUBERCULOSIS, PLEURISY, OR			20. HAS ANY APPLICATION YOU HAVE MADE					
BRONCHITIS?			FOR PRIVATE OR GOVERNMENT LIFE,					
10. DIABETES?			HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED					
11. ARTHRITIS, PARALYSIS, OR DISEASE,			APPROVED AT SUB-STANDARD RATES					
OR DEFORMITY OF THE BONES,			OR ON A DIFFERENT BASIS THAN					
MUSCLES, OR JOINTS? 12. DISEASE OR ULCER OF STOMACH,	++	\dashv	21. HEIGHT:FEETINCHES					
INTESTINES OR RECTUM?								
13. ANY DISEASE OF THE URINARY TRACT,	1		22: WEIGHT:POUNDS					
SUGAR, ALBUMIN, OR BLOOD IN URINE?								
23. REMARKS (Give complete details to "YES" answers. In	clude dat	es, di	iagnosis, physicians or hospitals, and names and addresses. Indic l. If additional space is needed, attach a separate sheet of paper)	cate				
after each disability whether service-connected or nonserv	ЛСЕ-СОни	!EC ieu	и и машиони зрасе в песаса, инаст и зератые знест ој рарстј					

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to VA any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise VA of any change of health condition arising after the signing and prior to delivery of this form to VA.

24A. SIGNATURE

24B. DATE