DEPARTMENT OF VETERANS AFFAIRS
Regional Office and Insurance Center
Wissahickon Avenue and Manheim Street
P.O. Box 7208
Philadelphia PA 19101

In Reply Refer To:

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Final Action on Your Government Life Insurance Application

We are unable to take final action on your application for Government life insurance.

(Insert the appropriate paragraph(s) noted on separate sheet.)

IMPORTANT

- It is important that the additional requirement be sent within days from the date of this letter. Otherwise, we may be unable to approve your application and the credit, if any, will be refunded.
- PLEASE TELL US PROMPTLY IF YOU CHANGE YOUR ADDRESS.

How to Contact VA About Government Life Insurance

- If you have any questions, call 1-800-669-8477 toll-free from anywhere in the USA.
- VA insurance representatives are available Monday through Friday from 8:30 a.m. to 6:00 p.m., EST.
- You may also visit our website at WWW.INSURANCE.VA.GOV.

Department of Veterans Affairs

OMB Control Number: 2900-0131
Respondent Burden: 20 minutes

Department of Veterans Affairs

REQUEST FOR SUPPLEMENTAL INFORMATION ON MEDICAL AND NONMEDICAL APPLICATIONS

1. FIRST-MIDDLE-LAST NAME OF INSURED	2. INSURANCE FILE NUMBER

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 38, Code of Federal Regulations 1.576 for routine uses identified in the 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.

RESPONDENT BURDEN: We need this information from you to take the necessary actions on your government life insurance. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 20 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/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PART I - CERTIFICATION OF HEALTH

1. I CERTIFY THAT to the best of my knowledge, I am now in as good health as I was on

Since that date, I have not been ill or suffered or contracted any disease, infirmity, or injury, nor have I been prevented by reason thereof from attending my usual occupation, nor have I consulted a physician, surgeon, or other practitioner for medical advice or treatment at home, hospital, or elsewhere in regard to my health, except as shown below. (This statement includes any treatment or examination by a VA physician or other physician acting on behalf of the VA, a medical officer in the active service of the Army, Navy, Air Force, Marine Corps or Coast Guard, or a physician of the Public Health Service. This statement refers to all disabilities, including any service disabilities.)

EXCEPTION: (Describe any illness, disease, injury or medical treatment, with dates. Also, give the names and addresses of any and all doctors, other practitioners, and/or hospitals concerned.)

2. DATE	3. SIGNATURE OF APPLICANT

PART II - HEALTH QUESTION - NONMEDICAL APPLICATION WITH ADVANCE EFFECTIVE DATE

1. ARE YOU NOW DISABLED? ☐ YES ☐ NO *(If "Yes," give facts below)*

2. DATE	3. SIGNATURE OF APPLICANT

PART III - DOCTOR'S CERTIFICATION

1. FIRST-MIDDLE-LAST NAME OF APPLICANT	2. SERVICE NO.	3. DATE EXAMINED

I CERTIFY THAT the above-named applicant was examined by me in connection with an application pertaining to Government Life insurance on the date specified in Part III, Item 3 above.

4. DATE OF SIGNATURE	5. SIGNATURE OF EXAMINER

NOTE: If the physician who made the examination is not available to complete the certification, a complete new physical examination report should be furnished.

(Paragraphs to be used on Page 1 of FL 29-615, as appropriate.)

1. The effective date you asked for is more than 31 days after the date of your application

2. You dated you application later than the date it was mailed.

3. Your payment of $ mailed on was too late for the premium due .

4. We need a payment of $. Please return this letter with your payment.

5. Your life insurance is in force because the extended term insurance continues for five years or more or through the endowment period. However, we need a certificate of health to reinstate your Total Disability Income Provision.

6. Please complete Part(s) on the form on page 2 of this letter and return with the payment, if requested.

7. The doctor who examined you did not sign and/or date your application. Please have him/her complete and return Part III on the form on page 2 of this letter.

8. You indicated that you had experienced illness, disease or injury since the date of lapse but you did not explain. Please explain in Part I, Item 1, "Exception", on the form on page 2 of this letter. Date and sign in Part I, Items 2 and 3 and return the form with a payment, if requested.

9. The amount we asked for on the form you received was quoted on the assumption there would be no delay in applying for the change. The additional amount is needed because the date of change is later than we had anticipated.