



DIRECT DEPOSIT ENROLLMENT/CHANGE

IMPORTANT NOTICE ABOUT INFORMATION COLLECTION: We need this information to determine, establish or verify your eligibility for VA Insurance benefits (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 2 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/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PRIVACY ACT NOTICE: The 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 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. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701)

1. NAME AND ADDRESS	2. INSURANCE FILE NUMBER
	3. SOCIAL SECURITY NUMBER (Must supply, if blank)
	4. DAYTIME TELEPHONE NUMBER ()

I hereby authorize the Department of Veterans Affairs to start direct deposit at the financial institution stated in Item 7, for the purpose of depositing directly into the account stated in Item 10, any and all Government Life Insurance payments that I am entitled to receive from all insurance policies under the insurance file number shown in Item 2.

5. SIGNATURE	6. DATE
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SECTION II - PLEASE ATTACH A VOIDED PERSONAL CHECK. IF YOU DO, SKIP BLOCKS 7-12. IF YOU DO NOT HAVE A CHECKING ACCOUNT, CONTACT YOUR BANK FOR HELP IN COMPLETING ITEMS 7-12

7. NAME OF BANK/FINANCIAL INSTITUTION	8. ROUTING TRANSIT NUMBER
9. ADDRESS OF BANK/FINANCIAL INSTITUTION	10. DEPOSITOR ACCOUNT NUMBER
11. TELEPHONE NUMBER OF BANK/FINANCIAL INSTITUTION ()	12. TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

13. DO YOU PARTICIPATE IN VAMATIC (AUTOMATIC DEDUCTION OF MONTHLY INSURANCE PREMIUM FROM A CHECKING ACCOUNT)?
 IF YES, DOES THIS CHANGE APPLY TO VAMATIC?
 YES NO

MAIL THE COMPLETED FORM TO:

**VAROIC - DD
 P.O. BOX 7208
 PHILADELPHIA, PA 19101-7208**

**IF YOU HAVE ANY QUESTIONS ABOUT DIRECT DEPOSIT, PLEASE CALL OUR TOLL-FREE NUMBER
 1-800-669-8477.**