

**Servicemembers' and Veterans' Group Life Insurance  
Accelerated Benefits Option**



**Administered by the  
Office of Servicemembers' Group Life Insurance  
80 Livingston Avenue  
Roseland, NJ 07068-1733  
Toll-Free: 1-800-419-1473  
Fax: (800) 236-6142**

# Instructions For Submitting a Claim for Accelerated Benefits

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## About The Accelerated Benefit

The accelerated benefit allows you to receive up to 50% of your Servicemembers' or Veterans' Group Life Insurance if you have been diagnosed by your physician as being terminally ill (as defined in Public Law 105-368) with nine (9) months or less to live. Only *you* (the insured) can apply for this benefit.

The amount of insurance proceeds payable to your beneficiary(ies) at the time of your death will be reduced by the amount of accelerated benefit you choose to receive now. Your premium will be lowered to reflect the reduced amount of your coverage.

## How To Claim This Benefit

To submit a claim for accelerated benefits, you, your physician and, if you're covered under SGLI, your branch of service must complete the attached forms as indicated at the top of each form. Once all forms are completed, you should send the forms to:

OSGLI ABO Claim Processing  
80 Livingston Avenue  
Roseland, NJ 07068-1733

## What You Should Know About Your Claim

You should be aware of the following before submitting your claim:

- Once we process your claim for accelerated benefits, we will send you a check for the amount you request\* and an explanation of the amount.
- Once you cash the payment, the accelerated benefit cannot be revoked.
- You can receive this benefit only once during your lifetime.
- You may use this benefit for any purpose you choose. Its use is not limited to medical expenses.
- If you're covered under SGLI, OSGLI will notify your branch of service to reduce the face amount of your coverage and your premium rate.
- If you die before cashing the accelerated benefit check, someone should return the check to OSGLI.
- If your claim is not approved, we will notify you. You will then have the chance to submit additional medical information. You can also reapply at a later date if you believe your condition will qualify you for this benefit.

\* The amount you request will be reduced by the amount of interest that would have been earned on it (over nine months) had you not claimed it. Therefore, the check you receive will be less than the amount you claim.

***If you have any questions, please call us toll-free at 1-800-419-1473. A customer service representative will assist you.***

**PRIVACY ACT STATEMENT** - Title 38 U.S Code, Chapter 19, Subchapter III, Servicemembers' Group Life Insurance, authorizes solicitation of this information. This information is needed to determine your eligibility for an "Accelerated Benefit Option" payment. Section 7701( c ) of Title 31, requires that any person doing business with the Federal Government furnish a Social Security Number or tax identification number. An accelerated benefit will not be paid to you unless a completed application has been received by the Office of Servicemembers' Group Life Insurance (Title 38, Section 1980).

**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 12 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 1-800-419-1473 for mailing information on where to send your comments.





## To Be Completed By Personnel Office of Servicemember's Unit

(Complete this form *only* if the applicant for Accelerated Benefits is covered under SGLI.)

### Branch of Service Statement

<i>Servicemember's Name</i>	<i>Social Security Number</i>	<i>Branch of Service</i>
<i>Amount of SGLI Coverage</i> \$	<i>Monthly Premium Amount</i> \$	
<i>Name of Person Completing This Form</i>	<i>Telephone Number</i>	<i>Fax Number</i>
<i>Title of Person Completing This Form</i>	<i>Duty Station and Address</i>	
<i>Signature</i> _____ <i>Date</i> _____ <i>of person</i> <i>completing this form</i>		

**Notice:** It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.