Department of Veterans Affairs

In Reply Refer To:

File Number:

If you have any questions about your insurance, call us toll-free at 1-800-669-8477.

OMB Control No. 2900-0128
Respondent Burden: 10 minutes

Department of Veterans Affairs

APPLICATION FOR REINSTATEMENT

Privacy Act Notice: 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 (i.e., to reinstate lapsed government life insurance) as 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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).

Respondent Burden: We need this information to determine your eligibility for reinstatement (38 U.S.C. 722). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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.

BE SURE TO INSERT ALL INFORMATION - DATE - SIGN AND MAIL IMMEDIATELY WITH THE TOTAL AMOUNT DUE

1A. AMOUNT OF INSURANCE TO BE REINSTATED	1B. AMOUNT OF TOTAL DISABILITY PROVISION TO BE REINSTATED	2. AMOUNT SENT WITH THIS APPLICATION	3. SOCIAL SECURITY NUMBER (Enter only if not previously reported to VA)

4. CERTIFICATION OF HEALTH

I am applying for reinstatement of my insurance in the amount shown above. As a condition to the reinstatement of this insurance, I certify that to the best of my knowledge, I am now in as good health as I was on the last day of the grace period (31 days after the payment due date).

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 state- ment includes any treatment or examination by a VA physician or other physician acting on behalf of 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. If additional space is needed, attach a separate piece of paper.

I understand that:

1. If my application for reinstatement is approved, the last designation of beneficiary and selection of optional settlement on the insurance reinstated will continue in effect, unless otherwise specified in writing over my signature and received by the Department of Veterans Affairs. (Use VA Form 29-336 to make any change.)
2. This application must be accompanied or preceded by the payment of the required premiums, as explained on the reverse.
3. If acceptable, reinstatement will be effective as of the premium due date immediately preceding the date this application is mailed or otherwise delivered to the Department of Veterans Affairs; except that when an acceptable application is mailed or otherwise delivered to the Department of Veterans Affairs on a premium due date, reinstatement will be effective as of that date.
4. In order to prevent a subsequent lapse of this insurance, premiums must be paid each month as they become due while this application is receiving consideration.
5. Any indebtedness against this insurance must be paid or reinstated.
6. Checks or money orders should be made payable to the Department of Veterans Affairs and mailed to this office.
7. The Department of Veterans Affairs may require a report of physical examination in connection with this application, if deemed necessary.
8. I am obliged to advise the Department of Veterans Affairs of any change of health condition arising after the date of execution of this form and prior to its delivery to the Department of Veterans Affairs.
9. Statements made by me in this application are relied upon. Any deception or false statement either by inference, omission, or otherwise may cause cancellation of the insurance or refusal to pay a claim. In either case, premiums may not be returned.

NOTE: If you are receiving VA benefits (compensation or pension) and the amount you receive each month equals or exceeds the monthly insurance premium, you may elect to have your insurance premium deducted from your check each month. If you are in active service or retired from active service, your monthly premium may be paid by an allotment from your Service Department. Premiums may also be paid by monthly deduction from your checking account. We will furnish you with further information upon request.

5. MAILING ADDRESS FOR INSURANCE PURPOSES	6. DAYTIME TELEPHONE NUMBER (Include Area Code) ( )

DATE OF MAILING AND DATE OF SIGNATURE MUST BE THE SAME.

7. DATE OF SIGNATURE	8. SIGNATURE OF INSURED (Do not print. This certification must be signed and dated.)
	SIGN HERE IN INK ▶

PENALTY - The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by fine or imprisonment or both.