



**APPLICATION FOR POLICY LOAN**  
GOVERNMENT LIFE INSURANCE

**PRIVACY ACT INFORMATION** - 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 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](http://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.

**RESPONDENT BURDEN** - 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 1.576 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 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. FIRST - MIDDLE - LAST NAME (Type or print)		2. INSURANCE FILE NUMBER <b>F</b>	
3. PERMANENT MAILING ADDRESS (Must be complete)		4. SOCIAL SECURITY NUMBER	
		5. DAYTIME TELEPHONE NUMBER	

6. POLICY NUMBER(S) ON WHICH LOAN IS REQUESTED (Include letter prefix)	7. AMOUNT OF LOAN DESIRED (Check one) <input type="checkbox"/> \$ _____ (AMOUNT) OR <input type="checkbox"/> MAXIMUM LOAN
--	--

8. DO YOU WISH TO USE DIVIDENDS TO REDUCE THE LOAN?

APPLY FUTURE DIVIDENDS TO PAY AN ANNUAL PREMIUM WITH THE REMAINING BALANCE APPLIED TO REDUCE THE LOAN

APPLY EXISTING DIVIDEND CREDIT/DEPOSIT TO REDUCE LOAN PRINCIPAL

APPLY FUTURE DIVIDENDS TO REDUCE LOAN PRINCIPAL

NOTE: Your VA compensation or pension or military retirement pay may be used to repay your loan. For more information, call the toll-free number below.

**IMPORTANT NOTICE**

**All new policy loans have a variable interest rate with a minimum rate of 5% and a maximum rate of 12%. The interest rate may change October of each year. The rate is based on the interest for long term Treasury bonds. Interest is payable yearly on the anniversary date of the loan.**

9. FULL SIGNATURE OF INSURED (Do not print)	10. DATE SIGNED
---	-----------------

**11. HOW WOULD YOU LIKE TO RECEIVE THIS PAYMENT?**

<input type="checkbox"/> <b>BY CHECK</b>	<b>OR</b>	<input type="checkbox"/> <b>BY DIRECT DEPOSIT</b>	NOTE: (The account must be in the name of the veteran. Direct Deposit will continue with all future payments to this account. You must notify us of any changes.)
<input type="checkbox"/> ADDRESS SHOWN IN BLOCK 3	A. NAME OF FINANCIAL INSTITUTION		B. TRANSIT/ROUTING NUMBER
<input type="checkbox"/> TEMPORARY ADDRESS SHOWN BELOW (Please print)	C. DEPOSITOR ACCOUNT NUMBER		D. TELEPHONE NUMBER OF FINANCIAL INSTITUTION
	E. ADDRESS OF FINANCIAL INSTITUTION		F. TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

**IMPORTANT** - After this form has been completed and signed, it should be mailed to:

Department of Veterans Affairs  
P.O. Box 7327  
Philadelphia, PA 19101

NOTE: IF YOU PREFER, INSTEAD OF MAILING THIS FORM, IT MAY BE FAXED TO (215) 381-3580.

PLEASE DO NOT RETURN YOUR POLICY WITH EITHER APPLICATION.

**QUESTIONS ABOUT YOUR INSURANCE? CALL US TOLL FREE AT 1-800-669-8477.**



**APPLICATION FOR CASH SURRENDER**  
**GOVERNMENT LIFE INSURANCE**

**PRIVACY ACT INFORMATION** - 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 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](http://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.

**RESPONDENT BURDEN** - 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 1.576 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 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. FIRST - MIDDLE - LAST NAME (Type or print)	2. INSURANCE FILE NUMBER F
3. PERMANENT MAILING ADDRESS (Must be complete)	4. POLICY NUMBER (Include letter prefix)
	5. DAYTIME TELEPHONE NUMBER (Include Area Code)
	6. SOCIAL SECURITY NUMBER

7. I HEREBY SURRENDER MY: (Check appropriate block)

BASIC INSURANCE POLICY                       BASIC INSURANCE AND PAID UP ADDITIONS

PAID UP ADDITIONS ONLY                       (USE SURRENDER VALUE TO BUY REDUCED PAID-UP INSURANCE)

PARTIAL SURRENDER OF PAID-UP ADDITION (AMOUNT OF CHECK) \$ \_\_\_\_\_

8. FUTURE DIVIDEND OPTION

PAY TO ME IN CASH                       APPLY TO PAY PREMIUMS IN ADVANCE                       HOLD ON DIVIDEND CREDIT

APPLY TO PAY INDEBTEDNESS                       APPLY TO BUY PAID-UP ADDITIONS                       HOLD ON DIVIDEND DEPOSIT

NETCASH                       NETLOLI                       NETPUA

NET OPTIONS - Dividend pays annual premium and remainder is used to reduce loan (NETLOLI), buy additional insurance (NETPUA), or refunded to veteran (NETCASH).

I hereby surrender all my right, title and interest in the basic insurance policy and/or paid-up additions represented by the policy number shown in Item 4 for the purpose of obtaining the cash surrender value.

9. FULL SIGNATURE OF INSURED (Do not print)	10. DATE SIGNED
---	-----------------

**11. HOW WOULD YOU LIKE TO RECEIVE THIS PAYMENT?**

<input type="checkbox"/> <b>BY CHECK</b> <b>OR</b>	<input type="checkbox"/> <b>BY DIRECT DEPOSIT</b> (NOTE: The account must be in the name of the veteran. Direct Deposit will continue with all future payments to this account. You must notify us of any changes.)	
<input type="checkbox"/> ADDRESS SHOWN IN BLOCK 3	A. NAME OF FINANCIAL INSTITUTION	B. TRANSIT/ROUTING NUMBER
	C. DEPOSITOR ACCOUNT NUMBER	D. TELEPHONE NUMBER OF FINANCIAL INSTITUTION
<input type="checkbox"/> TEMPORARY ADDRESS SHOWN BELOW (Please print)	E. ADDRESS OF FINANCIAL INSTITUTION	F. TYPE OF DEPOSITOR ACCOUNT
		<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

**IMPORTANT** - After this form has been completed and signed, it should be mailed to:

Department of Veterans Affairs  
P.O. Box 7327  
Philadelphia, PA 19101

**NOTE: IF YOU PREFER, INSTEAD OF MAILING THIS FORM, IT MAY BE FAXED TO (215) 381-3580.**

**PLEASE DO NOT RETURN YOUR POLICY WITH THIS APPLICATION**

**QUESTIONS ABOUT YOUR INSURANCE? CALL US TOLL-FREE AT 1-800-669-8477.**