OMB Control No. 2900-0011
Respondent Burden: 15 Minutes

Department of Veterans Affairs

APPLICATION FOR REINSTATEMENT

(NON MEDICAL - COMPARATIVE HEALTH STATEMENT)
GOVERNMENT LIFE INSURANCE

(For Use of VA Index)

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 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, 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 15 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 http://www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Use this form if you apply for reinstatement within 6 months from date of lapse. Before completing this form, please read the the IMPORTANT INFORMATION AND INSTRUCTIONS on back. Type or use ink. **All numbered items must be completed.**

1. INSURANCE FILE NO. *(Include letter prefix)*
F

2. FIRST NAME-MIDDLE NAME-LAST NAME OF INSURED *(Type or print)*

3. POLICY NO(S) TO BE REINSTATED

4. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or P.O., State and ZIP Code)*

5. SOCIAL SECURITY NUMBER

6. VA CLAIM NUMBER
C

7A. AMOUNT OF INSURANCE TO BE REINSTATED	7B. PLAN OF INSURANCE	7C. DATE OF LAPSE	7D. MONTHLY PREMIUM	7E. AMOUNT SENT WITH THIS APPLICATION
$			$	$

8. METHOD AND MODE OF PAYMENT FOR FUTURE PREMIUMS

A. METHOD

- ☐ DIRECT REMITTANCE TO THE DEPARTMENT OF VETERANS AFFAIRS
- ☐ MONTHLY DEDUCTION FROM VA PENSION OR COMPENSATION
- ☐ ALLOTMENT FROM ACTIVE SERVICE PAY OR SERVICE DEPARTMENT RETIREMENT PAY

B. AMOUNT OF MONTHLY PENSION OR COMPENSATION RECEIVED
$

C. MODE FOR DIRECT REMITTANCE

- ☐ MONTHLY
- ☐ QUARTERLY
- ☐ SEMI-ANNUALLY
- ☐ ANNUALLY

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 and belief, I am now in as good health as I was on the last day of the grace period (31 days after the date of lapse.)

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 to 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 acting on behalf of VA, a medical officer in the active service of the Army, Navy, Air Force, Marine Corps, 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. Use Item 9 , "REMARKS".

9. REMARKS

10. DATE OF SIGNATURE	11. SIGNATURE OF INSURED *(Do NOT print. This application must be signed and dated)*	12. TELEPHONE NUMBER *(Include Area Code)*

IMPORTANT INFORMATION AND INSTRUCTIONS

1. PURPOSE

This form may be used for reinstatement of Government Life Insurance when application is sent within 6 months from date of lapse.

2. PREMIUMS NEEDED FOR REINSTATEMENT

a. TERM POLICIES - Two premiums: One for the premium month of lapse and one for the premium month in which the application is sent to the Department of Veterans Affairs.

b. LIFE AND ENDOWMENT POLICIES - All unpaid premiums (without interest) on the amount of insurance to be reinstated.

3. DISPOSITION OF APPLICATION

When completed and signed by you, send application with payment (needed **IMMEDIATELY**) to:

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7208
Philadelphia, PA 19101

I UNDERSTAND THAT:

(a) If my application is approved, the last named beneficiary(ies) and selection of optional settlement(s) on the policy(ies) reinstated, will continue in effect unless the Department of Veteran Affairs receives a request for a change in writing over my signature. (VA Form 29-336 should be used to make any change).

(b) The amount of payment needed, as explained above, must be sent before or with this application.

(c) If my application is acceptable, my policy(ies) will be reinstated on the premium due date in the premium month my application is sent to the Department of Veterans Affairs. (For example: If an insurance policy was effective July 17, 1956, a premium month would always be from the 17th of each month through the 16th of the following month. If an application for reinstatement was sent January 4, the effective date of reinstatement would be December 17.) If an acceptable application is sent on a premium due date, reinstatement will be effective on that date.

(d) To prevent a lapse of my policy(ies) after applying for reinstatement premiums must be paid when due or within 31 days after the due date. If premiums are paid monthly, the next premium will be due on the first monthly premium due date after the date this application is sent to the Department of Veterans Affairs.

(e) Any indebtedness against my policy(ies) must be paid or reinstated.

(f) Checks or money orders should be made payable to the Department of Veterans Affairs and sent to the address shown above.

(g) The Department of Veterans Affairs will, if necessary, ask for a physical examination report in connection with this application.

(h) 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.

(i) I must let the Department of Veterans Affairs know of any change in my health beginning after the date I sign and before the date I send this form to the Department of Veterans Affairs.

(j) This form must be fully completed, signed by me and sent immediately to the address above.

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