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Department of Veterans	Affairs						
APPLICATION FOR REINSTATEMENT							
PRIVACY ACT INFORMATION - 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 as 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 required to obtain monthly payments of your Government Life Insurance. The responses you submit are considered confidential (38 USC 5701). Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in 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.							
REPONDENT BURDEN - We need this information to verify your eligibility for reinstatement of your Government Life Insurance(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 and 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 your comments about this form.							
BE S			L				
1. AMOUNT OF INSURANCE TO BE REINSTATED	2. AMOUNT OF TOTAL DISABILITY INCOME PROVISION TO BE REINSTATED	3. AMOUNT SENT WITH THIS APPLICATION	4. SOCIAL SECURITY NUMBER				
	5. CERTIFICATION OF HE	 ALTH					
A. 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 now as I was on the last day of the grace period (31 days after the date of lapse).							
	□ YES □ NO (If "NO", please fill out	<i>B</i>)					
B. Please describe any illness, disease, injury or medical treatment with dates, which have occurred since the date of lapse.							
	the last named beneficiary(ies) and selection of o						
 in effect unless the Department of Veterans Affairs receives a request for a change in writing over my signature. (VA Form 29-336 should be used to make any changes. B. 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. 							
C. 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.							
This form must be fully COMPLETED, SIGNED and sent IMMEDIATELY to the Department of Veterans Affairs address shown below where your insurance records are kept. Checks and money orders should be made payable to the Department of Veterans Affairs. Department of Veterans Affairs Regional Office and Insurance Center P.O. Box 7208 Philadelphia, PA 19101							
6. MAILING ADDRESS (Please complete onl	ly if your address shown on the front is not correct)	7. TELEPHONE	NUMBER				
8. SIGNATURE OF POLICYHOLDER (Do no	ot print. This certification must be signed and dated)	9. DATE OF SIG	NATURE				
PENALTY - The law provides that whoe	ver makes any statement of a material fact knowing it	to be false shall be punished by fine	e or imprisonment or both.				