



## CLAIM FOR ONE SUM PAYMENT GOVERNMENT LIFE INSURANCE

1. INSURANCE FILE NUMBER
2. INSURANCE POLICY NUMBER
3. NET AMOUNT OF INSURANCE
4. FIRST, MIDDLE, LAST NAME OF INSURED VETERAN
5. DATE OF DEATH
6. BENEFICIARY'S SHARE ( <i>Fraction</i> )

### INSTRUCTIONS

WE NEED A PHOTOCOPY OF THE VETERAN'S DEATH CERTIFICATE OR A STATEMENT FROM THE ATTENDING PHYSICIAN SHOWING DATE AND CAUSE OF DEATH. ONLY ONE CERTIFICATE OR STATEMENT IS REQUIRED FOR OUR RECORDS.

If the beneficiary is a minor or incompetent, the person having custody of the beneficiary should complete the form and give his/her address in Item 10. If you are signing as the guardian or attorney-in-fact, please include a copy of the court appointment or power of attorney.

Send this completed form to:

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

NOTE: If you prefer, instead of mailing this form, it may be FAXED to: 1-888-748-5822

7. FIRST, MIDDLE AND LAST NAME OF BENEFICIARY ( <i>Please print</i> )	8. RELATIONSHIP TO INSURED	9. DATE OF BIRTH OF BENEFICIARY
10A. MAILING ADDRESS ( <i>MUST BE COMPLETED</i> )		10B. BENEFICIARY'S SOCIAL SECURITY NUMBER
		10C. DAYTIME TELEPHONE NUMBER

**CERTIFICATION:** I certify that the above entries are true and correct to the best of my knowledge and belief.

11. SIGNATURE OF BENEFICIARY, FIDUCIARY OR GUARDIAN	12. DATE
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**IF DIRECT DEPOSIT IS DESIRED, ATTACH A VOIDED CHECK OR COMPLETE BLOCKS A THRU F. THE ACCOUNT MUST BE IN THE NAME OF THE BENEFICIARY. ITEM F MUST BE COMPLETED. IF THE BENEFICIARY IS A TRUST, ESTATE, OR REPRESENTED BY A FIDUCIARY, YOU MUST SEND A VOIDED CHECK FOR THAT SPECIFIC ACCOUNT AND COMPLETE ITEM G.**

A. NAME OF FINANCIAL INSTITUTION		B. ROUTING TRANSIT NUMBER ( <i>NINE DIGIT FIELD</i> )	
C. TELEPHONE NUMBER OF FINANCIAL INSTITUTION	D. TYPE <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS		E. DEPOSITOR ACCOUNT NUMBER
F. BENEFICIARY'S SOCIAL SECURITY NUMBER <i>(REQUIRED FOR DIRECT DEPOSIT)</i>	G. EIN OR TIN NUMBER ( <i>FOR TRUST OR ESTATE ONLY</i> )		

**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 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 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. 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 6 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.

**IF YOU HAVE QUESTIONS ABOUT THIS FORM, PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477**