OMB Control No. 2900-0149
Respondent Burden: 15 minutes
Expiration Date: XXXX

Department of Veterans Affairs

APPLICATION FOR CONVERSION GOVERNMENT LIFE INSURANCE

PRIVACY ACT INFORMATION: No insurance may be converted unless a completed application form has been received (38 U.S.C. 1904 and 1942). 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 1.526 for routine uses as identified in 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 or retain benefits. The responses you submit are considered confidential (38 USC 5701).

RESPONDENT BURDEN: This form is used by the insured to convert to a permanent plan of insurance. We need this information to determine what permanent plan of insurance the insured requested. 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: www.whitehouse.gov/omb/library/OMBNV.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

IMPORTANT
Answer all items. (See VA Pamphlet 29-73-1)
Do not return policy with this form

1. INSURANCE FILE NUMBER *(Include letter prefix)*

2. FIRST, MIDDLE, LAST NAME OF INSURED AND MAILING ADDRESS FOR INSURANCE PURPOSES *(Include number and street or rural route, city or P.O., State and ZIP Code)*

3. POLICY NUMBER TO BE CONVERTED *(Include letter prefix)*

4. VA CLAIM NUMBER *(If any)*

5. SOCIAL SECURITY NUMBER

6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

7A. PERMANENT PLAN(S) APPLIED FOR

- ☐ ORDINARY LIFE
- ☐ 20 PAYMENT LIFE
- ☐ 30 PAYMENT LIFE
- ☐ 20 YEAR ENDOWMENT
- ☐ ENDOWMENT AT AGE 60
- ☐ ENDOWMENT AT AGE 65
- ☐ MODIFIED LIFE 65
- ☐ MODIFIED LIFE 70

7B. AMOUNT OF INSURANCE TO BE CONVERTED

$

7C. IF YOU ARE NOT CONVERTING THE ENTIRE POLICY, DO YOU WISH TO CONTINUE ANY TERM INSURANCE?

☐ YES ☐ NO *(If "YES" enter amount $ _____)*

8. METHOD OF PREMIUM PAYMENT

A. DESIRED METHOD OF PAYMENT *(Check one)*

- ☐ DIRECT PAYMENT TO VA *(If checked, complete Item 8B)*
- ☐ MONTHLY DEDUCTION FROM VA PENSION OR COMPENSATION
- ☐ MONTHLY ALLOTMENT FROM RETIREMENT/ACTIVE SERVICE PAY
- ☐ VA MATIC *(Automatic Checking Account deduction)*

B. DESIRED METHOD FOR DIRECT PAYMENT OF FUTURE PREMIUMS *(Check one)*

- ☐ MONTHLY
- ☐ SEMI-ANNUAL
- ☐ QUARTERLY
- ☐ ANNUAL

9. PAYMENT AMOUNT

AMOUNT OF FIRST PREMIUM	$

10A. ARE YOU NOW DISABLED?

☐ YES ☐ NO *(If "YES," give name of disability below and complete Items 10B and 10C) (If "No," go to Item 11)*

10B. DATE LAST TREATED BY PHYSICAN OR HOSPITAL *(Include VA Physician or hospital)*

10C. DOES YOUR DISABILITY PREVENT YOU FROM WORKING?

☐ YES ☐ NO *(If "YES," explain fully)*

MAIL THE COMPLETED FORM TO:
VAROIC
P.O. BOX 42954
PHILADELPHIA, PA 19101

11A. SIGNATURE OF APPLICANT *(Application MUST be signed and dated in ink)(Do not print)*

11B. DATE OF APPLICATION

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE, CALL US TOLL-FREE AT 1-800-669-8477.