OMB Approved No. 2900-0139
Respondent Burden: 15 minutes
Expiration Dave: XX/XX/XXXX

Department of Veterans Affairs

NOTICE - PAYMENT NOT APPLIED

GOVERNMENT LIFE INSURANCE

NOTE: We are sorry the payment cannot be applied for the reason checked in Item 7.

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

2. POLICY NO. *(Including letter prefix)*

3. PREMIUM DUE DATE	4. AMOUNT OF PREMIUM	5. AMOUNT DUE	6. DATE PAYMENT SENT
	$	$	

(Please tell us promptly if you change your address)

7. REASON NOT APPLIED

A. PAYMENT NOT ACCEPTABLE *(Reason)*

- ☐ NOT SIGNED
- ☐ WRONG PAYEE - SHOULD BE PAYABLE TO DEPARTMENT OF VETERANS AFFAIRS

B. CHECK RETURNED FROM BANK *(Reason)*

- ☐ INSUFFICIENT FUNDS
- ☐ ACCOUNT CLOSED
- ☐ NO ACCOUNT
- ☐ CHECK POST DATED

8. DATE OF NOTICE

9. TO PROVIDE INSURANCE PROTECTION, PLEASE TAKE THE ACTION CHECKED BELOW *(DO NOT complete the reverse of this form unless paragraph 9e is checked)*

☐ a. Send us a payment for the amount in Item 5 no later than _____
The extra time allowed for submission of the payment is not an extension of the grace period. It is an adjustment which will be allowed provided the payment is made within the time specified and while you are living.

☐ b. Please send us a payment for the amount shown in Item 5 no later than _____
If you do not send us a payment by this date we will pay the monthly premium from your dividend credit account.

☐ c. Please send us a payment for the amount shown in Item 5 no later than _____
If payment is not sent before this date, add to the amount one additional monthly premium for each month of delay. If payment is not sent within 6 months from the date in Item 3, additional monthly premiums and interest will be required.

☐ d. Your check or money order was not acceptable because of an error. Reinstatement will not be necessary if within 31 days after the date in Item 8, you send us a statement from the bank that on the date the check was sent to us (See Item 6), the balance of the account was sufficient to cover the amount of the premium in Item 4.

☐ e. YOUR GOVERNMENT LIFE INSURANCE LAPSED ON THE DATE SHOWN IN ITEM 3. You may reinstate your policy by completing and returning the reinstatement application form on back, with a payment to cover the amount of premium needed for reinstatement (See Item 5). If you do not request reinstatement within 6 months from the date in Item 3, a physical examination report may be required to reinstate your insurance.

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

FROM ▶

DEPARTMENT OF VETERANS AFFAIRS
REGIONAL OFFICE AND INSURANCE CENTER
P.O. BOX 42954
PHILADELPHIA, PA 19101

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 can be located on the OMB Internet Page at: www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send your comments about this form.

BE SURE TO INSERT ALL INFORMATION - DATE - SIGN AND MAIL IMMEDIATELY WITH THE TOTAL AMOUNT

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 HEALTH

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 B)*

B. Please describe any illness, disease, injury or medical treatment with dates, which have occurred since the date of lapse.

I UNDERSTAND THAT:

A. If my application is approved, the last named beneficiary(ies) and selection of optional settlement(s) on policy(ies) reinstated, will continue 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. STATEMENT 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 only if your address shown on the front is not correct)*	7. TELEPHONE NUMBER
8. SIGNATURE OF POLICYHOLDER *(Do not print. This certification must be signed and dated)*	9. DATE OF SIGNATURE

PENALTY - The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by fine or imprisonment or both.