

<b>Department of Veterans Affairs</b> <b>APPLICATION FOR CHANGE OF PERMANENT PLAN (MEDICAL)</b> (CHANGE TO A POLICY WITH A LOWER RESERVE VALUE)	(For Use of VA Index)
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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 identified in 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. The responses you submit are considered confidential (38 USC 5701).

RESPONDENT BURDEN: We need this information to verify your eligibility to change your permanent plan (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 30 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/library/omb/OMBINV.VA.EPA.html#VA](http://www.whitehouse.gov/library/omb/OMBINV.VA.EPA.html#VA). If desired, you can call 1-800-827-1000 to get information on where to send your suggestions or comments about this form.

**INSTRUCTIONS**

This form is used to change a permanent plan of Insurance to another permanent plan with a lower reserve value.

The difference between the reserve of the two plans may be applied to a policy loan, applied to future premiums, or refunded to you in cash.

**REQUIREMENT:** You must be in good health to change to a plan with a lower reserve value. Please complete all the health questions on the back of this form.

The beneficiary and/or optional settlement under the new policy will remain the same as under the old policy. If a change is desired, submit VA Form 29-336, Designation of Beneficiary - Government Life Insurance.

It is not possible to change from a permanent plan to Term Insurance. Call our toll-free number for information on the available plans.

Complete and return this form to the following address:

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

**PART I - STATEMENT OF APPLICATION**

1. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED			2. INSURANCE FILE NUMBER <i>(Include letter prefix)</i>		
3. MAILING ADDRESS					
4. SOCIAL SECURITY NUMBER		5. VA FILE NUMBER <i>(If any)</i>		6. DAYTIME TELEPHONE NUMBER	
7. POLICY NUMBER	8. AMOUNT OF INSURANCE APPLIED FOR \$	9. PLAN OF INSURANCE APPLIED FOR	10. DO YOU WISH TO CONTINUE OR ADD THE TOTAL DISABILITY INCOME PROVISION <input type="checkbox"/> YES <input type="checkbox"/> NO		
11. DISPOSITION OF RESERVE CREDIT  <input type="checkbox"/> PAY FUTURE PREMIUMS <input type="checkbox"/> APPLY TO INDEBTEDNESS <input type="checkbox"/> PAY IN CASH					
12. METHOD OF PREMIUM PAYMENT  <input type="checkbox"/> DIRECT PAYMENT TO VA <i>(Complete Item 13)</i> <input type="checkbox"/> MONTHLY ALLOTMENT FROM SERVICE PAY <input type="checkbox"/> MONTHLY DEDUCTION FROM VA BENEFIT CHECK <input type="checkbox"/> MONTHLY DEDUCTION FROM YOUR CHECKING ACCOUNT					
13. MODE OF PREMIUM PAYMENT  <input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> ANNUALLY					

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

**PART II - EMPLOYMENT AND HEALTH INFORMATION**

The purpose of questions listed below is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.

It may be necessary to ask for a physical examination in connection with this application.

Please answer every question, date and sign this application.

NOTE: Complete the following employment questions. If additional space is needed, attach a separate sheet of paper.

1 A. ARE YOU NOW WORKING?  
 YES     NO

1 C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

1 B. DO YOU WORK FULL TIME?  
 YES     NO

**HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING: (Check all that apply)**

	YES	NO		YES	NO
2. DISEASE OF THE HEART OR ARTERIES; CHEST PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	14. ANY DISEASE OF THE PROSTATE OR TESTES IF A MALE; UTERUS, OVARIES OR BREAST IF A FEMALE?	<input type="checkbox"/>	<input type="checkbox"/>
3. HIGH BLOOD PRESSURE?	<input type="checkbox"/>	<input type="checkbox"/>	15. DO YOU USE OR HAVE YOU BEEN TREATED FOR THE USE OF ALCOHOL OR ANY HABIT FORMING DRUG?	<input type="checkbox"/>	<input type="checkbox"/>
4. CANCER, TUMOR OR POLYP?	<input type="checkbox"/>	<input type="checkbox"/>	16. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?	<input type="checkbox"/>	<input type="checkbox"/>
5. LUNG DISEASE?	<input type="checkbox"/>	<input type="checkbox"/>	17. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?	<input type="checkbox"/>	<input type="checkbox"/>
6. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?	<input type="checkbox"/>	<input type="checkbox"/>
7. EMOTIONAL OR MENTAL DISORDER?	<input type="checkbox"/>	<input type="checkbox"/>	19. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?	<input type="checkbox"/>	<input type="checkbox"/>
9. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?	<input type="checkbox"/>	<input type="checkbox"/>	20. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED APPROVED AT SUB-STANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?	<input type="checkbox"/>	<input type="checkbox"/>
10. DIABETES?	<input type="checkbox"/>	<input type="checkbox"/>			
11. ARTHRITIS, PARALYSIS, OR DISEASE, OR DEFORMITY OF THE BONES, MUSCLES, OR JOINTS?	<input type="checkbox"/>	<input type="checkbox"/>			
12. DISEASE OR ULCER OF STOMACH, INTESTINES OR RECTUM?	<input type="checkbox"/>	<input type="checkbox"/>	21. HEIGHT: _____ FEET _____ INCHES		
13. ANY DISEASE OF THE URINARY TRACT, SUGAR, ALBUMIN, OR BLOOD IN URINE?	<input type="checkbox"/>	<input type="checkbox"/>	22. WEIGHT: _____ POUNDS		

23. REMARKS (Give complete details to "YES" answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected or nonservice-connected. If additional space is needed, attach a separate sheet of paper)

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to VA any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise VA of any change of health condition arising after the signing and prior to delivery of this form to VA.

24A. SIGNATURE

24B. DATE