OMB Approved No. 2900-0068 Respondent Burden: 20 minutes Expiration Date: XX/XX/XXXX



Department of Veterans Affairs

APPLICATION FOR SERVICE-DISABLED VETERANS INSURANCE

IMPORTANT INFORMATION

Eligibility

S-DVI provides up to \$10,000 of life insurance for eligible veterans. To be eligible for S-DVI, you must meet **all three** of the following requirements:

- 1. You were released from active service in the Armed Forces on or after April 25, 1951, under other than dishonorable conditions.
- 2. It has been less than 2 years since VA notified you of a <u>new service-connected disability</u> or you are currently waiting for a rating for your service-connected disability. Please Note: The disability you are rated for must be a **new** disability, not an increase in a disability you already have. An increase to 100% or being granted individual unemployability **does not** automatically entitle you to a new eligibility period.
- 3. You are in good health **except for your service-connected disability.** We will evaluate all health conditions that are not service-connected. Information about any health conditions should be included on your application.

Cost

Before you apply for S-DVI coverage, we encourage you to compare our premium rates to commercial insurance companies. If your disability is not serious, you may be able to find better rates from a commercial company.

When considering the cost of S-DVI coverage, remember that if you are or become totally disabled and unable to work for six or more months you do not have to pay premiums on your Government Life Insurance policy. Most commercial life insurance companies add an additional charge for this benefit.

Speeding Up the Application Process:

We can process your application more quickly if you send us a copy of the letter from VA that <u>first</u> notified that your disability was rated service-connected within the last two years. You may also **apply online** by visiting our website at "<u>www.insurance.va.gov</u>" and clicking "Apply for Service-Disabled Veterans Insurance Online".

Mailing Address:

If you meet these criteria, please complete and sign the application and then send immediately to:

Department of Veterans Affairs Regional Office and Insurance Center (RH), P.O. Box 7208, Philadelphia, PA 19101, or fax to 1-888-748-5822.

Questions:

If you have questions about Government Life Insurance, you can call us toll-free at **1-800-669-8477** or visit our website at: **www.insurance.va.gov.**

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS APPLICATION 1. Name and Mailing Address for Insurance Purposes

A. First, Middle, Last Name	B. Mailing Address							
2. Beneficiary Designation and Selection of Settlement Option be paid to the surviving beneficiaries. For example, if you name thre beneficiaries.								
Complete Name and Address of Each Principal and Contingent Beneficiary (For married women, enter her own first and middle in For example, Mary Rose Smith, not Mrs. John Smith)	names.	Beneficiary's Social Security Number (If known. This is not required for this designation	Relationship of the beneficiary to you	Share to be paid to each beneficiary (Use \$ amounts, %, or fractions)	Payment Option for Each Beneficiary (See pamphlet for more information)			
PRINCIPAL		to be valid)						
					Lump Sum			
					Lump Sum			
Or to survivors					Lump Sum			
Contingent (Person(s) who get the proceeds if the principal beneficiary(ies) die before the insured.) If none, write "NON								
CONTINGENT					Lump Sum			
					Lump Sum			
Or to survivors					Lump Sum			

EVERY QUESTION MUST BE ANSWERED, BE SURE TO SIGN ON THIS SIDE									
	4. Social Security No.	5. Date	of Birth		6. Daytime Telephone		7. Email address		
		(Month,	, Day,Year	r)	(Include Area Code)				
8 ENTER THE	AMOLINT PLAN AND	DREMIL!	IM OF T	HE II	NSURANCE FOR V		DE ADDI VING		
8. ENTER THE AMOUNT, PLAN, AND PREMIUM OF THE INSURANCE FOR WHICH YOU ARE APPLYING (See Pamphlet 29-9 - Service-Disabled Veterans Insurance Information and Premium Rates)									
A. Amount of Insurance	B. Plan of Ir	surance				C. Monthly Pre	mium		
9A. Are you now working?	A. Are you now working? 9B. Do you work full-time? (If "Yes," skip to Item 10) 9C. If you are not working part-time, explain why (Please be specific)								
YES NO		NO							
9D. When did you last work full-time? 9E. What was your occupation?									
10. Check the method showing how you wish to pay for this insurance (If you are not eligible for waiver of premiums)									
A. I want to pay premiums by a monthly deduction from my VA Compensation or Pension. (We will start the deduction for you if the insurance is approved)									
B. I want to pay premiums by a monthly allotment from my military service/retirement pay. (We sill start the allotment for you if the insurance is approved)									
C. I want VA to automatically	y withdraw the premium ea	ch month	from my I	bank	account (VA MATIC) (Send your first pa	yment with this application)		
D. I will send premiums direct	ctly to VA as follows (Send)	our first po	ayment wii	th this	application)				
Monthly Quarterly Semi-Annually Annually									
working Qua	iteriy oeiiii-Aiiilde	411y		any					
11. Have you had any of the follow	wing:	YES	NO		f your answer to any pa				
A. Lung condition?					luration and other deta eparate sheet)	IIS. (If more space	e is needed, attach a		
B. Mental or nervous disorders?									
C. Blood disorder?									
D. Heart condition?									
E. Cancer or tumor?									
F. Diabetes?									
13. Have you had any other physi	cal defect or disease? (If "	YES", expla	iin below)		YES NO				
CERTIFICATION: I have reviewed all of my answers above and certify that they are true and correct to the best of my knowledge and belief.									
14A. Signature of Applicant (Do No	OT print, sign in ink)					14B. D	ate		
Privacy Act Notice: VA will not disc 38, Code of Federal Regulations 1.57	close information collected or '6 for routine uses identified in	this form the VA sy	to any sou	urce of	ther than what has been a s. 36VA00. Veterans and	uthorized under the Armed Forces Pe	he Privacy Act of 1974 or Title ersonnel U.S. Government Life		
Insurance Records-VA, published in voluntary. Refusal to provide your so	the Federal Register. Your ob	ligation to	respond is	s requi	ired to obtain this benefit	. Giving us your s	ocial security number is		
provide his or her social security num	iber unless the disclosure of the	ne social se	curity nur	mber i	s required by a Federal S	tatute of law in ef	fect prior to January 1, 1975, and		
still in effect. Respondent Burden: We need this i	nformation to determine your	eligibility	for VA In	surana	ce benefits (38 U.S.C. 19	22). Title 38. Uni	ted States Code, allows us to ask		

Respondent Burden: We need this information to determine your eligibility for VA Insurance benefits (38 U.S.C. 1922). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 20 minutes to review the information, 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 comments or suggestions about this form.