DEPARTMENT OF VETERANS AFFAIRS

Regional Office and Insurance Center
Wissahickon Avenue and Manheim Street
P.O. Box 7208
Philadelphia, PA 19101

In Reply Refer To:

The insured veteran named above has filed a claim for disability benefits on his/her Government life insurance and indicates that you treated him/her from .
We would appreciate you providing the information on the following page. The veteran's claim for benefits authorizes us to request this information from you. Thank you for your help.

How to Contact VA About Government Life Insurance

- If you have any questions, call 1-800-669-8477 toll-free from anywhere in the USA
- VA insurance representatives are available Monday through Friday from 8:30 a.m. to 6:00 p.m., EST
- You may also visit our website at WWW.INSURANCE.GOV

Department of Veterans Affairs

(Over)

OMB Control Number: 2900-0120
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

PRIVACY ACT INFORMATION: 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 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 voluntary, but your failure to provide us the information could impede processing. The responses you submit are considered confidential (38 U.S.C. 5701).
Respondent Burden: We need this information to determine 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 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 displayed. Valid OMB control numbers can be located on the OMB Internet page at www.whitehouse.gov/library/omb/OMBINVC.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

ITEMS THAT MAY NEED TO BE COMPLETED

(Please complete the items marked below)

1. DATE SYMPTOMS FIRST APPEARED (OR DATE OF ACCIDENT)

2. DATE FIRST TREATED FOR THIS CONDITION

3. DATE THE INSURED BECAME UNABLE TO WORK

4. DATE YOU LAST SAW THE INSURED

5. OBJECTIVE SYMPTOMS/DIAGNOSES

6. SINCE FIRST TREATMENT, HAS CONDITION OF INSURED *(Check one)*

☐ REMAINED THE SAME ☐ IMPROVED ☐ WORSENED

7. CAN THE INSURED PERFORM HIS/HER NORMAL OCCUPATION?

☐ YES ☐ NO

8. IS THE INSURED EXPECTED TO IMPROVE TO THE POINT WHERE EMPLOYMENT WOULD BE POSSIBLE?

☐ YES ☐ NO

9A. SIGNATURE OF PHYSICIAN	9B. DATE SIGNED