

IN REPLY REFER TO:

FILE NUMBER:

You are now approaching your 65th birthday, and we would like to take this opportunity to remind you about a very important provision of the Government life insurance policy you selected. Your policy, , is known as a Modified Life policy. This means that the amount of your insurance coverage will automatically reduce by one-half from its present face value of \$ to \$ on the day before your birthday.

Your premiums are currently being waived because you were found to be totally disabled for insurance purposes. If your premiums are still being waived at the time of reduction of your policy, you **will not** have to apply for the additional insurance. We will automatically issue you an Ordinary Life policy to replace the amount of Modified Life insurance being discontinued. Premiums on both policies will continue to be waived as long as you remain totally disabled.

QUESTIONS ABOUT YOUR INSURANCE? CALL US TOLL-FREE AT 1-800-669-8477. OUR HOURS OF OPERATION ARE 8:30 AM TO 6:00 PM EASTERN TIME. THE BEST DAYS TO CALL ARE WEDNESDAY AND THURSDAY. INFORMATION ABOUT MODIFIED LIFE REDUCTION

OMB Control No. 2900-0166 Respondent Burden: 5 minutes

4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my of the insurance coverage that will end on the day before my of the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			Expiration Date: XX/XX/XXXX
REPLACEMENT INSURANCE FOR MODIFIED LIFE REDUCED 18. NEW POLICY NO. (Assigned by F.4) PRIVACY ACT - No insurance may be granted unless a completed application has been received (38 U.S.109). The information organized may reduine use identified in the VA system of records, 36VA00, Veterans and Armed Forces. Concernment II formance Records - VA, publication the reducal Regimes of Government into the VA system of records, 36VA00, Veterans and Armed Forces. RESPONDENT BURDEN - VA may not conduct or sponsor, and respondent is not required to respond to this collection of information are stimated to average 5 minutes per response, including the time for reviewing the burden estimate or any other aspect of this collection of information are stimated to average 5 minutes per response, including the time for reviewing the burden estimate or any other aspect of this collection of information, call 1.800-827-1000 for mating information on where its send year comments. IMPORTANT - This application and the first premium must be submitted to the Department of Veterans Affairs BEFORE your 65th birthday. 2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (<i>brech</i>) 4. MALING ADDRESS FOR INSURANCE PURPOSES (<i>Number and street or rural route, city or post affice</i> , STATE and Zip Code) 1 I wish to apply for the amount of insurance shown in the block to the right as the address shown on the reverse. 0. AMOUNT OF INSURANCE APPLIED FOR Sign in May CUDDERSTAND that the benchicary designation and optional settlement under this new policy will be the same as on my Modified Life policy and was menual Labamia change in writing to the Department of Veterans Affairs. </th <th>Department of Veterans Affairs</th> <th></th> <th>1A. INSURANCE FILE NUMBER</th>	Department of Veterans Affairs		1A. INSURANCE FILE NUMBER
REPLACEMENT INSURANCE FOR MODIFIED LIFE REDUCED 18. NEW POLICY NO. (Assigned by F.4) PRIVACY ACT - No insurance may be granted unless a completed application has been received (38 U.S.109). The information organized may reduine use identified in the VA system of records, 36VA00, Veterans and Armed Forces. Concernment II formance Records - VA, publication the reducal Regimes of Government into the VA system of records, 36VA00, Veterans and Armed Forces. RESPONDENT BURDEN - VA may not conduct or sponsor, and respondent is not required to respond to this collection of information are stimated to average 5 minutes per response, including the time for reviewing the burden estimate or any other aspect of this collection of information are stimated to average 5 minutes per response, including the time for reviewing the burden estimate or any other aspect of this collection of information, call 1.800-827-1000 for mating information on where its send year comments. IMPORTANT - This application and the first premium must be submitted to the Department of Veterans Affairs BEFORE your 65th birthday. 2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (<i>brech</i>) 4. MALING ADDRESS FOR INSURANCE PURPOSES (<i>Number and street or rural route, city or post affice</i> , STATE and Zip Code) 1 I wish to apply for the amount of insurance shown in the block to the right as the address shown on the reverse. 0. AMOUNT OF INSURANCE APPLIED FOR Sign in May CUDDERSTAND that the benchicary designation and optional settlement under this new policy will be the same as on my Modified Life policy and was menual Labamia change in writing to the Department of Veterans Affairs. </td <td>APPLICATION FOR ORDINARY LIFE</td> <td>INSURANCE</td> <td>]</td>	APPLICATION FOR ORDINARY LIFE	INSURANCE]
be used by VA employees and your authorized north the finance of Government instance of Government instance of Government instance of Government in the disclosure is and the disclosure is alticlicated units of the VA system of records, 36VA00, Veterans and Armed Forces S, Government Lite Insurance Records - VA, published in the Federal Register. RESPONDENT BURDEN - VA may not conduct or sponse, and respondent is not required to respond to this collection of information unless it displays control Number, Public porting Burden for the collection of information. If you have comments are stimated to arready a simulate or arready and maintaining the data needed, and completing and reviewing the collection of information. If you have comments in the burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to stend your comments. IMPORTANT - This application and the first premium must be submitted to the Department of Veterans Affairs BEFORE your 65th birthday. 2. FIRST - MIDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclust representation on where to stend your comments. 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or raral route, city or post office. STATE and Zip Code) 3. AMOUNT OF INSURANCE APPLIED FOR INSURANCE APPLIED FOR Strength and the insurance coverage that will end on the day before my for the same as on my Modified Life policy and was an unit a advang in writing to the Department of Veterans Affairs at the address shown on the reverse. 1. Wish to apply for the amount of insurance shown in the block to the right as not may Modified Life policy and was an unit a advang in writing to the Department of Veterans Affairs. 6. AMOUNT OF INSURANCE APPLIED FOR the unumber of the D	REPLACEMENT INSURANCE FOR MODIFIED L	IFE REDUCED	1B. NEW POLICY NO. (Assigned by VA)
Control Number. Public propring burden for this collection of information is estimated in average 5 minutes per response, including the time for reviewing searching existing and completing and reviewing the collection of information, and reviewing the collection of information, and reviewing the collection of information, call 1-800-827-1000 for mailing information on where to send your comments. IMPORTANT - This application and the first premium must be submitted to the Department of Veterans Affairs BEFORE your 65th birthday. 2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclu) 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 1 1 wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my sense using uniting index as on my Modified Life policy and was mere util submit a change in writing to the Department of Veterans Affairs 6. SIGNATURE OF INSURED // INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 5. AMOUNT OF INSURANCE APPLIED FOI 1 wish to apply for the amount of insurance shown in the block to the right as mere as on my Modified Life policy and was mere util submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in tok) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.	e used by VA employees and your authorized representatives in the maint he disclosure is authorized under the Privacy Act, including the routine uses	enance of Government insurance s identified in the VA system of r	e programs. Responses may be disclosed outside VA only it
2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclu 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 1 wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. 1 UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 5. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION	Control Number. Public reporting burden for this collection of information is earching existing data sources, gathering and maintaining the data needed, a	is estimated to average 5 minutes and completing and reviewing the	s per response, including the time for reviewing instructions, e collection of information. If you have comments regarding
2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclu 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. 5. AMOUNT OF INSURANCE APPLIED FOR State of the policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclu 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. 5. AMOUNT OF INSURANCE APPLIED FOR State of the policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
2. FIRST - MIDDLE - LAST NAME OF INSURED 3. DAYTIME TELEPHONE NUMBER (Inclu 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) 1 wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. 1 UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 5. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION			
4. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street or rural route, city or post office, STATE and Zip Code) I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my AMOUNT OF INSURANCE APPLIED FOR the amount of the Department of Veterans Affairs. SIGNATURE OF INSURED (Do not print. Sign in ink) DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.	MPORTANT - This application and the first premium must be submitted t	to the Department of Veterans Af	fairs BEFORE your 65th birthday.
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. SIGNATURE OF INSURED (Do not print. Sign in ink) T. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.	. FIRST - MIDDLE - LAST NAME OF INSURED		3. DAYTIME TELEPHONE NUMBER (Include Area Code
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.	. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and street of	r rural route, city or post office, s	STATE and Zip Code)
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (<i>Do not print. Sign in ink</i>) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			
65th birthday. I UNDERSTAND that the beneficiary designation and optional settlement under this new policy will be the same as on my Modified Life policy and w same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.		-	5. AMOUNT OF INSURANCE APPLIED FOR
same until I submit a change in writing to the Department of Veterans Affairs. 6. SIGNATURE OF INSURED (Do not print. Sign in ink) 7. DATE OF APPLICATION When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.	•	e day before my	
When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.			he same as on my Modified Life policy and will remain the
	. SIGNATURE OF INSURED (Do not print. Sign in ink)		7. DATE OF APPLICATION
		nent of Veterans Affairs at the ad-	dress shown on the reverse
VA FORM 29-8700C SUPERSEDES VA FORM 29-8700C, MAR 1999, WHICH WILL NOT BE USED			