Prudential

Office of Servicemembers' Group Life Insurance

OMB Approved No. 2900-XXXX
Respondent Burden: 25 Minutes
Expiration Date: XX/XX/XXXX

Please send the completed form and all attachments to:

OSGLI
PO Box 41618
Philadelphia, PA 19176

SGLI Disability Extension Application and Instructions

IMPORTANT INFORMATION ABOUT THE SERVICEMEMBERS' GROUP LIFE INSURANCE (SGLI) DISABILITY EXTENSION

The SGLI Disability Extension provides coverage for up to two years from your date of separation at no cost to you. The SGLI Disability Extension is available to Veterans who are totally disabled and had SGLI coverage at the time of their separation from service. To be considered totally disabled, you must have any impairment of mind or body which continuously renders it impossible for you to follow any substantially gainful occupation, OR have one of the following conditions, regardless of employment status:

1. Permanent loss of use of any of the following:
   - both hands
   - both feet
   - both eyes
   - one foot and one eye
   - one hand and one foot
   - one hand and one eye
2. Total loss of hearing in both ears
3. Organic loss of speech (lost ability to express oneself, both by voice and whisper, through normal organs for speech. Note: Being able to speak with an artificial appliance is still considered a loss of speech.)

For more information about the SGLI Disability Extension, please visit: www.benefits.va.gov/insurance/sglidisabled.asp

HOW TO APPLY FOR THE SGLI DISABILITY EXTENSION

To apply for the SGLI Disability Extension, please complete the Veteran's Statement and have your physician complete and sign the Physician's Statement. Be sure to follow the instructions below.

1. **Veteran Information:** All information in this section is required. Be sure to include the amount of your SGLI coverage at separation.
2. **Eligibility:** Answer all questions in this section and include the requested documentation with your application.
3. **Veteran's Impairment Statement:** Please answer all questions regarding your impairment.
4. **Work Status:** Provide information about your current work status and employment history. If you need to provide more information than the space allows, please attach a separate sheet of paper with details.
5. **Veteran's Signature:** Sign and date the application where indicated.
6. **HIPAA Authorization Form:** Complete and sign the Authorization Form. Give it to your physician along with the Physician's Statement.
7. **Physician's Statement:** Have your physician complete and sign the Physician's Statement.
8. **Mail your completed application and any required documentation to the address above or fax to 800-236-6142.**

Important: Be sure to include a copy of your most recent separation orders and your most recent Leave and Earnings Statement (LES) with your application. You may also send in a copy of your DD-214 or NGB22 in lieu of your separation orders and LES.

If your application is approved:

- You will receive written notification of your approval from the Office of Servicemembers' Group Life Insurance (OSGLI).
- Your SGLI coverage will be extended for a maximum of two years from your date of separation or until you are able to work, whichever comes first.
- Prior to the end of your SGLI Disability Extension you will receive a billing statement for Veterans' Group Life Insurance (VGLI). Your VGLI coverage will begin the day after your SGLI Disability Extension ends, provided we've received your first VGLI premium payment. If you do not want VGLI, simply disregard the billing statement and you will not be enrolled for coverage.

If your application is not approved:

- You will be enrolled in VGLI if the date of receipt of this application is within 240 days of your date of separation and we've received your first VGLI premium payment. You will begin receiving billing statements from OSGLI and will continue to have VGLI as long as you pay the premiums. If you do not want VGLI, simply disregard the billing statement and you will not be enrolled for coverage.
- If the date of receipt of this application is after 240 days from your date of separation, it will automatically be considered an application for VGLI. You will be asked to provide proof of good health and your first VGLI premium payment to complete your application. If you are approved for VGLI coverage, you will begin receiving billing statements from OSGLI. If you are not approved for coverage, then your first VGLI premium payment will be refunded.

QUESTIONS?

If you have any questions, please send an email to sgli.extension@prudential.com or call 800-419-1473, Monday through Friday, between 8:00 a.m. and 5:00 p.m. Eastern Time.

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Please send the completed form and all attachments to:

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SGLI Disability Extension Application
Veteran's Statement

Please read the instructions on page 1 before completing this form.

1 Veteran Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

Address Line 1

Address Line 2

City | State | ZIP Code

Country | Phone Number

Email Address

Date of Separation (MM DD YYYY) | Branch of Service | SGLI Coverage Amount $,

2 Eligibility

Has VA rated you totally disabled based on individual unemployability*? ☐ Yes ☐ No

If yes, please include a copy of the decision document from VA with your application.

*Unemployability means that VA has determined that you are incapable of obtaining or maintaining gainful employment due to your disability.

3 Veteran's Impairment Statement

Do you have any of the following conditions?

• Permanent loss of use of both hands	☐ Yes	☐ No
• Permanent loss of use of both feet	☐ Yes	☐ No
• Permanent loss of use of both eyes	☐ Yes	☐ No
• Permanent loss of use of one hand and one foot	☐ Yes	☐ No
• Permanent loss of use of one foot and one eye	☐ Yes	☐ No
• Permanent loss of use of one hand and one eye	☐ Yes	☐ No
• Total loss of hearing in both ears	☐ Yes	☐ No
• Organic loss of speech*	☐ Yes	☐ No

*Organic loss of speech is the lost ability to express oneself, both by voice and whisper, through normal organs for speech. Note: Being able to speak with an artificial appliance is still considered a loss of speech.

Important: If you checked yes to any of the conditions above, please include either a copy of your VA rating decision for the condition OR other medical proof of your condition.

Veteran's Last Name | Last 4 digits of Social Security Number

4 Work Status

Choose the box that describes your current work status:

- ☐ I am currently working more than 20 hours per week.
- ☐ I am currently working 20 hours per week or less.
- ☐ I am currently working with special conditions or accommodations, as approved by my employer. A special condition or accommodation is any condition or accommodation without which an individual would be unable to work without more supervision or assistance than required by other workers performing similar work.
- ☐ I am not currently working, but have worked since I separated from service.
- ☐ I have not worked since my separation from service due to my disability.

Provide your work history since your separation from service in the chart below. Include any periods of self-employment. If you need more space than is allowed, use a separate sheet of paper and include it with your application. If you have not worked since separating from service, do not complete.

Name and address of employer	Type of work (e.g., seasonal, occasional, or year-round)	Average number of hours worked per week	Dates of employment	
			From (mm/dd/yyyy)	To (mm/dd/yyyy)

5 Veteran's Signature

X _____ Date of Signature (MM DD YYYY)

Veteran's Signature

Important: Be sure to include a copy of your most recent separation orders and Leave and Earnings Statement (LES) with your application. You may also send in a copy of your DD-214 or NGB22 in lieu of your separation orders and LES.

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Office of Servicemembers' Group Life Insurance

Authorization Form

Authorization for Release of Information to the Office of Service-members' Group Life Insurance

This Authorization is intended to comply with the HIPAA Privacy Rule

Claimant's Social Security Number

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Office of Servicemembers' Group Life Insurance (OSGLI) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: P.O. Box 984, Roseland, NJ 07068. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my (his/her) complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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SGLI Disability Extension Application Physician's Statement

Instructions to the Physician: Your patient has requested coverage under the Servicemembers' Group Life Insurance (SGLI) Disability Extension program. Answer, fully and completely, all applicable parts of this form. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be as specific as you can.

Patient's First Name | MI | Last Name

Patient's Social Security Number

Does the patient have an impairment of mind or body that continuously renders it impossible for him/her to follow any substantially gainful occupation? ☐ Yes ☐ No

If you answered yes above, please provide details below. Include the date the impairment began and date the impairment prevented the patient from gainful employment.

What is the patient's clinical diagnosis? ICD-9-Code Diagnosis Date (MM DD YYYY)

Primary: _____

Secondary: _____

Secondary: _____

Please describe any relevant test procedures performed.

Please describe any relevant surgical procedures performed.

Please list any medications the patient is currently taking.

Was the patient hospitalized? ☐ Yes ☐ No

If yes, provide dates of hospitalization:

From (MM DD YYYY) To (MM DD YYYY)

Patient's Last Name | Last 4 digits of Social Security Number

Has the patient worked since his/her impairment began? ☐ Yes ☐ No ☐ Don't know

Is the patient working against your advice and is such work harming the patient's health or substantially aggravating the patient's impairment? ☐ Yes ☐ No

If you answered yes above, please provide details below.

Is the patient capable of handling his/her own affairs? ☐ Yes ☐ No

Physician's Name | MI | Last Name

Physician's Specialty | Physician's Phone Number

Physician's Address

City | State | ZIP Code

Date of Signature (MM DD YYYY)

X

Physician's Signature