OMB Approved No. 2900-0016
Respondent Burden: 1 hour 45 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

CLAIM FOR DISABILITY INSURANCE
GOVERNMENT LIFE INSURANCE

INFORMATION AND INSTRUCTIONS

THIS APPLICATION IS TO BE COMPLETED BY VETERANS WHO HAVE GOVERNMENT LIFE INSURANCE AND BECOME TOTALLY DISABLED.

TOTAL DISABILITY:

1. Any impairment of mind or body which makes it impossible for the veteran to be gainfully employed.
2. Total Disability must start before the veteran's 65th birthday.

WAIVER REFUND

1. Premium Refunds limited to one year prior to date the claim is filed, unless there were circumstances beyond the veteran's control (such as a severe mental disability). **LACK OF KNOWLEDGE OF THE WAIVER PROVISION IS NOT A CIRCUMSTANCE BEYOND THE VETERAN'S CONTROL.**
2. If total disability started more than one year prior to the date of your claim, and you believe a mental disability prevented you from filing an earlier claim, please include a statement explaining these circumstances on a separate sheet of paper. **YOU SHOULD ALSO INCLUDE ANY MEDICAL EVIDENCE WHICH SUPPORTS YOUR STATEMENT.**

PART I should be completed by the insured veteran if able; if not, by a person acting on his/her behalf.

PART II should be completed by the insured veteran's physician or hospital official. If there will be a delay in preparing Part II send Part I immediately.

NOTE: IF THE VETERAN HAS BEEN GRANTED DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION, PLEASE ATTACH A COPY OF THE AWARD LETTER.

PART I

1. FIRST, MIDDLE, LAST NAME OF INSURED *(Type or print)*	2. INSURANCE FILE NUMBER *(Include letter prefix)*
3. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and Street or Rural Route, City or P.O., State and ZIP Code)*	4. SOCIAL SECURITY NUMBER
	5. DATE OF BIRTH
	6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*
	7. CLAIM NUMBER

8. DATE DISABILITY PREVENTED EMPLOYMENT	9. DATE RETURNED TO GAINFUL EMPLOYMENT

10A. EDUCATION *(Check highest years completed) (If you have any other specialized training or education please complete Item 10B)*

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐1 ☐2 ☐3 ☐4	☐1 ☐2 ☐3 ☐4
(Grade School)	*(High School)*	*(College)*

10B. PLEASE PROVIDE ANY SPECIALIZED TRAINING IN THE SPACE PROVIDED BELOW

11. ARE YOU RECEIVING OR HAVE YOU APPLIED FOR ANY DISABILITY BENEFITS AS LISTED BELOW?	12. DISEASE OR INJURY CAUSING TOTAL OR PERMANENT DISABILITY
☐ VA DISABILITY COMPENSATION ☐ VA PENSION ☐ SOCIAL SECURITY DISABILITY	

IF YOU HAVE ANY QUESTIONS ABOUT DISABILITY BENEFITS OR YOUR INSURANCE, PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477

13. HOSPITALS WHERE YOU HAVE BEEN TREATED, INCLUDING VA HOSPITALS

NAME OF HOSPITAL	ADDRESS OF HOSPITAL	DATE OF ADMISSION	DATE OF RELEASE

14. PHYSICIANS WHO HAVE TREATED YOU FOR DISEASE OR INJURY, CAUSING TOTAL PERMANENT DISABILITY

NAME OF PHYSICIAN	ADDRESS OF PHYSICIAN	DATE TREATMENT BEGAN	DATE OF LAST TREATMENT

15. RECORD OF EMPLOYMENT FOR ONE YEAR PRIOR TO THE DATE OF TOTAL DISABILITY TO THE PRESENT *(Include self-employment)*

DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WORKED	EARNINGS
FROM	TO	DATE	WEEKLY	WEEKLY
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	REASON FOR TERMINATION OF EMPLOYMENT	
DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WORKED	EARNINGS
FROM	TO	DATE	WEEKLY	WEEKLY
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	REASON FOR TERMINATION OF EMPLOYMENT	
DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WORKED	EARNINGS
FROM	TO	DATE	WEEKLY	WEEKLY
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	REASON FOR TERMINATION OF EMPLOYMENT	

I consent that any physician or hospital who has treated or examined me for any purpose, or who I have consulted professionally, any insurance company or organization to which I have applied for insurance, or any person, persons, firm or corporation to whom, or to which I have applied for employment or disability benefits, may provide to the Department of Veterans Affairs or testify as to, or produce in court, any information obtained concerning myself by reason of the foregoing, and waive any privileges which render such information confidential. A photostatic copy of this consent shall be considered valid authorization for release of information to VA. I certify that each question has been truthfully and completely answered to the best of my knowledge.

16. DATE OF SIGNATURE	17. SIGNATURE OF INSURED *(Or official or fiduciary completing form for insured)*

PENALTY - The law provides that whomever makes any statement of a material fact, knowing it to be false, shall be punished by fine or imprisonment or both.

REPORT FOR DISABILITY INSURANCE PURPOSES OF TREATMENT IN A HOSPITAL OR FROM AN ATTENDING PHYSICIAN

PART II

Part II of this application should be completed by the appropriate hospital official or by the veteran's attending physician. If appropriate hospital summaries are available, please forward with application.

1. FIRST, MIDDLE, LAST NAME OF INSURED *(Type or print)*	2. INSURANCE FILE NUMBER *(Include letter prefix)*

3. HOME ADDRESS *(Number and Street or Rural Route, City or P.O., State and ZIP Code)*	**FOR VA USE ONLY**	
	4. CLAIM NUMBER	5. SOCIAL SECURITY NUMBER

6. HISTORY *(Conditions causing disability)*

A. WHEN DID INJURY OR ILLNESS BEGIN?	B. DATE INSURED STOPPED WORKING BECAUSE OF DISABILITY

C. DATE OF FIRST TREATMENT	D. FREQUENCY AND NATURE OF TREATMENT

E. OBJECTIVE SYMPTOMS AND FINDINGS WHEN FIRST SEEN	F. DIAGNOSIS, INCLUDE RESULTS OF SPECIAL STUDIES

7. HOSPITALIZATION

DATE		NAME AND ADDRESS OF HOSPITAL	CONDITION AT DISCHARGE
FROM	TO		

8. PROGNOSIS

A. DATE OF LAST EXAM OR TREATMENT	B. OBJECTIVE FINDINGS

C. DIAGNOSIS - CONDITIONS CAUSING DISABILITY	D. IS VETERAN CAPABLE OF DOING ALL OF HIS/HER WORK? ☐ YES ☐ NO E. IS VETERAN CAPABLE OF DOING ANY OTHER WORK? ☐ YES ☐ NO

F. CARDIAC FUNCTION *(Check if applicable)*

☐ AHA FUNCTIONAL CAPACITY - CL 1 *(NO LIMITATION)*
☐ AHA FUNCTIONAL CAPACITY - CL 3 *(MARKED LIMITATION)*
☐ AHA FUNCTIONAL CAPACITY - CL 2 *(SLIGHT LIMITATION)*
☐ AHA FUNCTIONAL CAPACITY - CL 4 *(COMPLETE LIMITATION)*

G. MENTAL/NERVOUS IMPAIRMENT *(Ability to function in stressful situations and engage in interpersonal relations) (Check if applicable)*	H. SINCE FIRST TREATMENT HAS VETERAN
☐ NO LIMITATION ☐ SLIGHT LIMITATION ☐ MODERATE LIMITATION ☐ MARKED LIMITATION ☐ SEVERE LIMITATION	☐ IMPROVED ☐ WORSENED ☐ REMAINED THE SAME

9. NAME AND ADDRESS OF ATTENDING PHYSICIAN OR HOSPITAL

10. DATE OF REPORT	11. SIGNATURE AND TITLE OF PERSON PREPARING REPORT

When completed and signed, send this claim form IMMEDIATELY to the office of the Department of Veterans Affairs where the Insurance Records are maintained. The address of the Department of Veterans Affairs office that maintains these records is:

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