OMB Control No. 2900-0011
Respondent Burden: 30 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

APPLICATION FOR REINSTATEMENT (INSURANCE LAPSED MORE THAN 6 MONTHS)
GOVERNMENT LIFE INSURANCE AND/OR TOTAL DISABILITY INCOME PROVISION

(FOR USE BY VA INDEX)

PRIVACY ACT NOTICE: 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. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information to determine, establish or verify your eligibility for VA insurance benefits (38 CFR 8.24 and 6.80). Title 38, United States Code, allows us to ask for this information. We estimate you will need an average of 30 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 not displayed. Valid OMB control numbers can be located on the OMB Internet page at http://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.

INSTRUCTIONS

Use this form for reinstatement of your Government Life Insurance and/or Total Disability Income Provision when application is made more than 6 months after the date of lapse regardless of age.

Amount of payment needed for reinstatement:

TERM POLICIES - Two premiums; One for the premium month of lapse and one for the premium month in which the application is sent to the Department of Veterans Affairs.

LIFE AND ENDOWMENT POLICIES - All unpaid premiums with interest on the amount of insurance to be reinstated. Please call our toll-free number (1-800-669-8477) for instructions to calculate the amount of payment (premium and interest) needed to reinstate your policy(ies).

When completed and signed by you, send this application with payment needed to:

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

SECTION I - APPLICANT'S INFORMATION

1A. FIRST - MIDDLE - LAST NAME OF INSURED	1B. INSURANCE FILE NUMBER *(Include letter prefix)*

2. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or P.O., State and ZIP Code)*

3. SOCIAL SECURITY NUMBER	4. VA CLAIM NUMBER *(If any)*	5. DAYTIME TELEPHONE NUMBER

6. POLICY NUMBER(S) TO BE REINSTATED

7A. AMOUNT OF INSURANCE TO BE REINSTATED	7B. PLAN OF INSURANCE	7C. DATE OF LAPSE	7D. MONTHLY PREMIUM	7E. AMOUNT SENT WITH THIS APPLICATION *(INS)*
$			$	

7F. AMOUNT OF TOTAL DISABILITY INCOME PROVISION TO BE REINSTATED	7G. DATE OF LAPSE	7H. MONTHLY PREMIUM	7I. AMOUNT SENT WITH THIS APPLICATION *(TDIP)*
		$	$

8. TOTAL AMOUNT SENT $

I UNDERSTAND THAT:

1. The amount of payment needed must be sent before or with this application. Checks and money orders should be made payable to the Department of Veterans Affairs.
2. The Department of Veterans Affairs will, if necessary, ask for a physical examination report in connection with this application.

SECTION II - STATEMENT OF APPLICANT (Please answer every question, date and sign this statement)

INFORMATION: The purpose of questions contained in STATEMENT OF APPLICANT is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in refusal to pay a claim on the policy.

9A. ARE YOU NOW WORKING?	9B. DO YOU WORK FULL-TIME?
☐ YES ☐ NO	☐ YES ☐ NO

9C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

10. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

	YES	NO		YES	NO
A. DISEASE OF THE HEART OR ARTERIES, CHEST PAIN?	☐	☐	H. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?	☐	☐
B. HIGH BLOOD PRESSURE?	☐	☐	I. DIABETES?	☐	☐
C. CANCER, TUMOR OR POLYP?	☐	☐	J. ARTHRITIS, PARALYSIS, OR DISEASE OR DEFORMITY OF THE BONES, MUSCLES OR JOINTS?	☐	☐
D. LUNG DISEASE?	☐	☐	K. DISEASE OR ULCER OF STOMACH, INTESTINES, OR RECTUM?	☐	☐
E. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?	☐	☐	L. DISEASE OF THE URINARY TRACT, SUGAR, ALBUMIN, OR BLOOD IN URINE?	☐	☐
F. EMOTIONAL OR MENTAL DISORDER?	☐	☐	M. ANY DISEASE OF THE PROSTATE OR TESTES IF A MALE, UTERUS, OVARIES OR BREASTS IF A FEMALE?	☐	☐
G. DISEASE OF THE BLOOD?	☐	☐	N. DO YOU USE OR HAVE YOU BEEN TREATED FOR USE OF ALCOHOL OR ANY HABIT FORMING DRUG?	☐	☐

11. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?	12. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?	13. DO YOU HAVE ANY SERVICE-CONNECTED DISABILITIES?	14. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

15. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED, APPROVED AT SUBSTANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?	16A. YOUR HEIGHT	16B. YOUR WEIGHT
☐ YES ☐ NO	FEET INCHES	POUNDS

17. REMARKS *(Give complete details to YES answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected or nonservice-connected. If additional space is needed, attach a separate sheet of paper)*

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally, may divulge to the Department of Veterans Affairs any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of those answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise the Department of Veterans Affairs of any change of health condition arising after the signing and prior to the delivery of this form to the Department of Veterans Affairs.

18A. SIGNATURE	18B. DATE

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE, CALL TOLL-FREE 1-800-669-8477