

APPLICATION FOR SUPPLEMENTAL SERVICE-DISABLED **VETERANS INSURANCE (SRH)**

IMPORTANT INFORMATION

Supplemental Service-Disabled Veterans Insurance offers up to \$30,000 in additional coverage to disabled veterans who:

- 1. Have Service-Disabled Veterans Insurance (RH) coverage in force, and
- 2. Have obtained a waiver of premiums on their Service-Disabled Veterans Insurance (RH) coverage.

Eligible veterans must apply for Supplemental Service-Disabled Veterans Insurance (SRH) within one year from receiving a notice from the VA Insurance Center that their application for waiver of premiums on their Service-Disabled Veterans Insurance (RH) coverage was approved **OR** before your 65th birthday, whichever comes first.

If you do not have Service-Disabled Veterans Insurance (RH) coverage, you cannot apply for Supplemental Service-Disabled Veterans Insurance. Instead use VA Form 29-4364, Application for Service-Disabled Veterans Insurance to apply for coverage.

Premiums

Veterans whose application for Supplemental Service-Disabled Insurance (SRH) is approved, must pay premiums for this coverage. There is no waiver of premiums for this additional coverage.

Mailing Address

If you meet these criteria, please complete and sign the application and then send immediately to:

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

Beneficiary Designation

The beneficiary designation on this form will change all previous designations under this file number unless you checked the box in Item 11 stating that you only wanted the change to apply to your Supplemental policy. You can change your beneficiary at any time; we simply need the change in writing. Please keep a copy of this designation with your important papers.

What Your Beneficiary Must Do To File For Death Benefits

We will be able to pay your insurance as quickly as possible, if your beneficiary completes the following steps when filing a claim for your insurance:

- 1. Mail or fax us a letter saying that he or she is the beneficiary of your government life insurance. Your beneficiary must sign the letter using his or her own full name. The letter should include:
 - The Insurance File Number (shown on the other side of this form on the top right)
 - \bigcirc His or her relationship to you (spouse, child, friend, etc.)

 - His or her Social Security Number
 The address where the check is to be mailed **OR** the name of the bank with the routing and account Ō
 - numbers for the account you would like the money deposited in
 - A daytime telephone number, including the area code
- 2. Attach a copy of the death certificate to the letter. The death certificate should show the cause of death. It does not need to be notarized, a copy is acceptable.
- 3. Mail or fax the letter and death certificate to:

Via Mail: Department of Veterans Affairs

Regional Office and Insurance Center

P.O. Box 7208 (Attn: SRH) Philadelphia, PA 19101

Via Fax: Toll-Free at 1-888-748-5822

If you have questions about Government Life Insurance, you can call us toll-free at **1-800-669-8477**. Insurance Specialists are available from Monday through Friday, 8:30 a.m. to 6:00 p.m., Eastern time. We recommend that you call on Wednesdays, Thursdays, or Fridays when you can reach us more quickly. You can also visit our website at www.insurance.va.gov. The website provides detailed information on a range of topics, including applying for insurance and filing death claims.

1. First Name, Middle Name, Last Name of Insured			3. Insurance File Number			
2. Mailing Address for Insurance Purposes		4. Social Security Number				
			5. Date	e of Birth (Month, Day, Year	r)	
					,	
			6. Day	Time Telephone Number	(Include Area Code)	
			7. Ema	il Address		
Enter the amount, plan, and premium of the in Insurance Information and Premium Rates)	nsurance for which you are	e applying.	(See Pa	mphlet 29-9 - Service-Dis	sabled Veterans	
A. Amount of Insurance B	. Plan of Insurance	C. Monthly Premium				
9. Check the method showing how you wish to ր	pay for this insurance					
☐ A. I want to pay premiums by a monthly d	eduction from my VA Com	pensation	or Pensi	ion. (We will start the dedu the insurance is appro	action for you if oved)	
☐ B. I want to pay premiums by a monthly allotment from my military service/retire				rement pay. (We will start the allotment for you if the insurance is approved)		
☐ C. I want VA to automatically withdraw the	e premium each month from	m my bank	accoun	t (VA MATIC) (Send your with this ap	first payment plication)	
☐ D. I will send premiums directly to VA as f	follows: (Send your first pay	ment with t	his applic	cation)	,	
☐ Monthly ☐ Quarterly ☐	Semi-Annually	Annually				
10. Beneficiary Designation and Optional Settle	ment					
Complete Name and Address of Each Principal and Contingent Beneficiary (For married women, enter her own first and middle names. For example, Mary Rose Smith, not Mrs. John Smith)	Beneficiary's Social Security Number (If known. This is not required for this designation be valid)	Relationsh beneficiary		Share to be paid to each beneficiary (Use \$ amounts %, or fractions)	Payment Option for Each Beneficiary (See pamphlet for more information)	
					Lump Sum	
					Lump Sum	
					Lump Sum	
Or to survivors					Lump Sum	
Contingent (Person(s) who get the proceeds if the principal beneficiary(ies) die before the insured. If none, write "NONE"						
					Lump Sum	
					Lump Sum	
					Lump Sum	
					Lump Sum	
11. This beneficiary change cancels all prior Benunder my file number unless the box is chec	cked.					
I would like this change to apply only to my Supplemental Service-Disabled designation on all other insurance policies under the above file number.						
12. Signature of Applicant (Do NOT print, sign in ink)			13. Date			
Privacy Act Notice: VA will not disclose information collof Federal Regulations 1.576 for routine uses identified in to VA, published in the Federal Register. Your obligation to r	the VA system of records, 36VA	00, Veterans	and Armed	d Forces Personnel U.S. Govern	ment Life Insurance Records -	

Privacy Act Notice: 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 38, Code of Federal Regulations 1.576 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. 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 establish your eligibility for VA Insurance benefits (38 U.S.C. 1922). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 20 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 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.