



## APPLICATION FOR CONVERSION GOVERNMENT LIFE INSURANCE

**PRIVACY ACT INFORMATION:** No insurance may be converted unless a completed application form has been received (38 U.S.C. 1904 and 1942). 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 as identified in VA system of records, 36VA29, Veterans and Uniformed Services Personnel Programs of U.S. Government Life Insurance - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The responses you submit are considered confidential (38 USC 5701).

**RESPONDENT BURDEN:** This form is used by the insured to convert to a permanent plan of insurance. We need this information to determine what permanent plan of insurance the insured requested. We estimate that you will need an average of 15 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](http://www.reginfo.gov/public/do/PRAMain). If desired, you can call 1-800-827-1000 to get information on where to send your comments about this form

<p><b>IMPORTANT</b>  <b>Answer all items. (See VA Pamphlet 29-73-1)</b>  <b>Do not return policy with this form</b></p>	<p>1. INSURANCE FILE NUMBER <i>(Include letter prefix)</i></p>
<p>2. FIRST, MIDDLE, LAST NAME OF INSURED AND MAILING ADDRESS FOR INSURANCE PURPOSES <i>(Include number and street or rural route, city or P.O., State and ZIP Code)</i></p>	<p>3. POLICY NUMBER TO BE CONVERTED <i>(Include letter prefix)</i></p>
	<p>4. VA CLAIM NUMBER <i>(If any)</i></p>
	<p>5. SOCIAL SECURITY NUMBER</p>
	<p>6. DAYTIME TELEPHONE NUMBER <i>(Include Area Code)</i></p>
<p>7A. PERMANENT PLAN(S) APPLIED FOR</p> <p><input type="checkbox"/> ORDINARY LIFE                      <input type="checkbox"/> ENDOWMENT AT AGE 60</p> <p><input type="checkbox"/> 20 PAYMENT LIFE                      <input type="checkbox"/> ENDOWMENT AT AGE 65</p> <p><input type="checkbox"/> 30 PAYMENT LIFE                      <input type="checkbox"/> MODIFIED LIFE 65</p> <p><input type="checkbox"/> 20 YEAR ENDOWMENT                      <input type="checkbox"/> MODIFIED LIFE 70</p>	<p>7B. AMOUNT OF INSURANCE TO BE CONVERTED</p> <p>\$ _____</p> <p>7C. IF YOU ARE NOT CONVERTING THE ENTIRE POLICY, DO YOU WISH TO CONTINUE ANY TERM INSURANCE?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <i>(If "YES" enter amount \$ _____)</i></p>
<p><b>8. METHOD OF PREMIUM PAYMENT</b></p>	
<p>A. DESIRED METHOD OF PAYMENT <i>(Check one)</i></p> <p><input type="checkbox"/> DIRECT PAYMENT TO VA <i>(If checked, complete Item 8B)</i></p> <p><input type="checkbox"/> MONTHLY DEDUCTION FROM VA PENSION OR COMPENSATION</p> <p><input type="checkbox"/> MONTHLY ALLOTMENT FROM RETIREMENT/ACTIVE SERVICE PAY</p> <p><input type="checkbox"/> VA MATIC <i>(Automatic Checking Account deduction)</i></p>	<p>B. DESIRED METHOD FOR DIRECT PAYMENT OF FUTURE PREMIUMS <i>(Check one)</i></p> <p><input type="checkbox"/> MONTHLY                                      <input type="checkbox"/> SEMI-ANNUAL</p> <p><input type="checkbox"/> QUARTERLY                                      <input type="checkbox"/> ANNUAL</p>
<p><b>9. PAYMENT AMOUNT</b></p>	
<p>AMOUNT OF FIRST PREMIUM    ▶    \$ _____</p>	
<p>10A. ARE YOU NOW DISABLED?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <i>(If "YES," give name of disability below and complete Items 10B and 10C) (If "No," go to Item 11)</i></p>	<p>10B. DATE LAST TREATED BY PHYSICIAN OR HOSPITAL  <i>(Include VA Physician or hospital)</i></p>
<p>10C. DOES YOUR DISABILITY PREVENT YOU FROM WORKING?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO    <i>(If "YES," explain fully)</i></p>	
<p>MAIL THE COMPLETED FORM TO:          VARIOIC          P.O. BOX 42954          PHILADELPHIA, PA 19101</p>	
<p>11A. SIGNATURE OF APPLICANT <i>(Application MUST be signed and dated in ink) (Do not print)</i></p>	<p>11B. DATE OF APPLICATION</p>

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