OMB Control No. 2900-0166
Respondent Burden: 5 minutes
Expiration Date: XXXXXXX

Department of Veterans Affairs

APPLICATION FOR ORDINARY LIFE INSURANCE

REPLACEMENT INSURANCE FOR MODIFIED LIFE REDUCED AT AGE 65
NATIONAL SERVICE LIFE INSURANCE

1. INSURANCE FILE NUMBER *(Include letter prefix)*

2. POLICY NUMBER ON NEW INSURANCE *(To be assigned by VA)*

PRIVACY ACT INFORMATION: 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 VA system of records, 36VA29, Veterans and Uniformed Services Personnel Programs of U.S. Government Life Insurance - VA, and 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: We need this information from you to purchase additional government life insurance. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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.

IMPORTANT - This application and the initial premium must be submitted to the Department of Veterans Affairs before your 65th birthday.

3. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED

4A. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or P.O., State and ZIP Code)*

4B. IS THIS A CHANGE OF ADDRESS FOR YOUR INSURANCE RECORDS? *(Check one)*

☐ YES ☐ NO

5. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

I wish to apply for the amount of insurance shown in Item 6, the block to the right, as replacement for the insurance that will end on the day before my 65th birthday.

6. AMOUNT OF INSURANCE APPLIED FOR

I understand that the beneficiary designation and optional settlement under this new policy will remain the same as that on my Modified Life policy and will remain so until I submit a change in writing to the Department of Veterans Affairs.

7. SIGNATURE OF INSURED *(Do not print) (Sign in ink)*

8. DATE OF APPLICATION

9. PLEASE MAIL THIS APPLICATION TO THE VA OFFICE BELOW.

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 7787
Philadelphia, PA 19101

VA FORM XXXX **29-8485**

SUPERSEDES VA FORM 29-8485, OCT 2014, WHICH WILL NOT BE USED.