OMB Approved No. 2900-0166
Respondent Burden: 5 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

APPLICATION FOR ORDINARY LIFE INSURANCE

REPLACEMENT INSURANCE FOR MODIFIED LIFE REDUCED AT AGE 70 NATIONAL SERVICE LIFE INSURANCE

1A. INSURANCE FILE NUMBER

1B. NEW PLOICY NO. *(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: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-821-1000 for mailing information, call 1-800-827-1000 for mailing information on where to send your comments.

IMPORTANT *- This application and the first premium must be submitted to the Department of Veterans Affairs BEFORE your 70th birthday.*

2. FIRST NAME, MIDDLE NAME AND LAST NAME OF INSURED	3. DAYTIME TELEPHONE NUMBER

4. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or post office, STATE and Zip Code)*
(COMPLETE ONLY IF DIFFERENT THAN THAT SHOWN OF REVERSE)

I wish to apply for the amount of insurance shown in the block to the right as replacement for the insurance coverage that will end on the day before my 70th birthday.	5. AMOUNT OF INSURANCE APPLIED FOR $

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

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

When completed, mail this application and the first premium to the Department of Veterans Affairs at the address shown on the reverse.

VA FORM XXXX **29-8701**

SUPERSEDES VA FORM 29-8701, MAR 2014, WHICH WILL NOT BE USED.