OMB Control No. 2900-0020
Respondent Burden: 10 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

SUPPLEMENTAL DESIGNATION OF BENEFICIARY - GOVERNMENT LIFE INSURANCE

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly and using capital letters to expedite processing of the form.

VETERAN'S SOCIAL SECURITY NUMBER

___ – ___ – ____

CHECK BOX IF YOU WANT THIS DESIGNATION TO ONLY APPLY TO A SPECIFIC POLICY ► ☐

Insurance Policy Number:

IMPORTANT - The beneficiaries listed below are in addition to those listed on my completed VA Form 29-336, *Designation of Beneficiary - Government Life Insurance* that was signed on _____ *(Date Signed).*

SECTION I - BENEFICIARY DESIGNATION INFORMATION - PRINCIPAL

IMPORTANT - The total for all principal beneficiaries **must** equal **100%**.

FIRST PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF PRINCIPAL BENEFICIARY

PRINCIPAL BENEFICIARY SOCIAL SECURITY NUMBER

___ – ___ – ____

PRINCIPAL BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month __ – Day __ – Year ____

PRINCIPAL BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code ____ – ____

PRINCIPAL BENEFICIARY EMAIL ADDRESS

PRINCIPAL BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** ___ **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

SECOND PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF PRINCIPAL BENEFICIARY

PRINCIPAL BENEFICIARY SOCIAL SECURITY NUMBER

___ – ___ – ____

PRINCIPAL BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month __ – Day __ – Year ____

PRINCIPAL BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code ____ – ____

PRINCIPAL BENEFICIARY EMAIL ADDRESS

PRINCIPAL BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** ___ **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

THIRD PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF PRINCIPAL BENEFICIARY

PRINCIPAL BENEFICIARY SOCIAL SECURITY NUMBER

– –

PRINCIPAL BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month Day Year

– –

PRINCIPAL BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

PRINCIPAL BENEFICIARY EMAIL ADDRESS

PRINCIPAL BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

SECTION II - BENEFICIARY DESIGNATION INFORMATION - CONTINGENT

FIRST CONTINGENT BENEFICIARY IDENTIFYING INFORMATION

IMPORTANT - The total for all contingent beneficiaries **must** equal **100%**.

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF CONTINGENT BENEFICIARY

CONTINGENT BENEFICIARY SOCIAL SECURITY NUMBER

– –

CONTINGENT BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month Day Year

– –

CONTINGENT BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

EMAIL ADDRESS

DAYTIME TELEPHONE NUMBER (Include Area Code)

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

SECOND CONTINGENT BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF CONTINGENT BENEFICIARY

CONTINGENT BENEFICIARY SOCIAL SECURITY NUMBER

– –

CONTINGENT BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month Day Year

– –

SECOND CONTINGENT BENEFICIARY IDENTIFYING INFORMATION *(Continued)*

CONTINGENT BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

CONTINGENT BENEFICIARY EMAIL ADDRESS

CONTINGENT BENEFICIARYHDAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** ☐☐☐ **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

THIRD CONTINGENT BENEFICIARY IDENTIFYING INFORMATION *(Continued)*

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ LEGAL ENTITY

FIRST NAME - MIDDLE INITIAL - LAST NAME OF CONTINGENT BENEFICIARY

CONTINGENT BENEFICIARY SOCIAL SECURITY NUMBER

– –

CONTINGENT BENEFICIARY DATE OF BIRTH *(MM,DD,YYYY)*

Month – Day – Year

CONTINGENT BENEFICIARY MAILING ADDRESS *(Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

EMAIL ADDRESS

DAYTIME TELEPHONE NUMBER (Include Area Code)

INSURANCE PAYMENT DISTRIBUTION

LUMP SUM **SHARE %** ☐☐☐ **OR** **EQUAL SHARES (Check box if you want equal share distribution) ►** ☐

SECTION III - ADDITIONAL INSTRUCTIONS

YOUR INSURANCE PROCEEDS WILL BE AUTOMATICALLY PAID ACCORDING TO THE AUTOMATIC SURVIVORSHIP CLAUSE DETAILED IN SECTION 5 BELOW. IF YOU DO NOT WANT YOUR INSURANCE PAID THIS WAY, PLEASE EXPLAIN BELOW HOW YOU WANT IT PAID. ALSO, LIST THE POLICY NUMBER OF ANY POLICY ON WHICH THE BENEFICIARY IS NOT TO BE CHANGED.

SECTION IV - CERTIFICATION AND SIGNATURE

I Certify that I am the policyholder and I understand that:

1. Unless otherwise noted in Section IV, Additional Instructions, my insurance will be paid according to the automatic survivorship clause as follows:

   - If one or more principal beneficiary dies before me, the insurances will be divided between any remaining principal beneficiaries.
   - If all principal beneficiaries die before me, the insurance will be paid to my contingent beneficiaries.
   - If all principal and contingent beneficiaries die before me, the insurance will be paid to my estate.

2. This change cancels all prior beneficiary and option selections; and unless indicated in Section IV, Additional Instructions, this change applies to all Government Life Insurance policies.

3. By law, if a designated principal beneficiary does not file a claim for payment within two years of the date of my death, then payment may be made to the beneficiary(ies) next entitled. If no claim for payment is received from any designated beneficiary within four years of the date of my death, my insurance will be paid in accordance with 38 U.S.C. 1917(f). If I do not designate a beneficiary, my insurance will be paid to my estate or to my heirs.

IMPORTANT - The veteran must sign and date the form. A person holding a Power of Attorney or Guardianship cannot sign the form. Please call our toll-free number at 1-800-669-8477 if the veteran is unable to sign. The signature date must be the date the veteran actually signed the form.

SIGNATURE OF VETERAN *(Sign in ink)*	DATE SIGNED (MM/DD/YYYY Month – Day – Year
	☐☐ – ☐☐ – ☐☐☐☐

THIS COMPLETED FORM MAY BE SUBMITTED BY:

MAIL	FAX	ONLINE
VARO & IC (B&O) **P. O. Box 8638** **Philadelphia, PA 19011**	**1-888-748-5822**	**Upload the form using our secure website at** **www.insurance.va.gov**

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 as identified in the 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 voluntary. VA uses your Social Security number (SSN) to identify your insurance file. Providing your SSN will help ensure that your records are properly associated with your insurance file. 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.

RESPONDENT BURDEN: We need this information to determine your eligibility for 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 10 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.