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

Department of Veterans Affairs

DESIGNATION OF BENEFICIARY - GOVERNMENT LIFE INSURANCE

NOTE: Before completing the form, please consider updating your beneficiary designation online at **https://www.insurance.va.gov/home.**

SECTION I - VETERAN'S IDENTIFYING INFORMATION *(All information requested in this section is required)*

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.

1. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN

2. SOCIAL SECURITY NO. ___ – ___ – ____

3. DATE OF BIRTH *(MM,DD,YYYY)*
Month ___ – Day ___ – Year ____

4. VETERAN'S 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 –

5. EMAIL ADDRESS

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

7. CHECK BOX IF YOUR ADDRESS HAS CHANGED ► ☐

IMPORTANT - IF YOU DO NOT NAME A SPECIFIC BENEFICIARY, YOUR INSURANCE WILL BE PAID TO YOUR ESTATE. THIS DESIGNATION WILL APPLY TO ALL POLICIES UNLESS YOU INDICATE OTHERWISE BY CHECKING THE BOX BELOW.

8. CHECK BOX IF YOU WANT THIS DESIGNATION TO ONLY APPLY TO A SPECIFIC POLICY ► ☐
(If checked, enter policy number below)

Policy Number:

INSTRUCTIONS FOR COMPLETING THIS FORM

Use this form to designate or make changes to the beneficiary(ies) of your Government Life insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary without anyone knowing or consenting to it. You may change your beneficiary at any time by completing a new Government Life Insurance Beneficiary Designation form. This form ***cannot*** be used to reinstate your coverage if your insurance is not in force due to failure to pay timely premiums.

INSTRUCTIONS FOR DESIGNATING A PRINCIPAL OR CONTINGENT BENEFICIARY (Section II)

- You may name more than one principal and more than one contingent beneficiary. This form allows you to name up to three principal and three contingent beneficiaries. Please use VA Form 29-336a, *Supplemental Designation of Beneficiary* to list additional beneficiaries.
- You have the right to change your beneficiary at any time without the knowledge or consent of the prior beneficiary. A state court or divorce decree cannot restrict this right and is not binding on you.
- You may name as beneficiary any person, firm, corporation or other legal entity, including your estate.

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.

SECTION II - BENEFICIARY DESIGNATION INFORMATION - PRINCIPAL

Principal Beneficiaries are the person(s) or entity(ies) you choose to receive your life insurance proceeds. **Payment will be made in equal shares unless otherwise specified**. In the event that a designated principal beneficiary predeceases you, the proceeds will be paid to the remaining principal beneficiaries in equal shares or all to the sole remaining principal beneficiary. For more information about alternatives to the automatic survivorship clause or lump sum payment, please call our toll-free number 1-800-669-8477.

I HEREBY REVOKE ANY PREVIOUS DESIGNATION OF PRINCIPAL BENEFICIARY(IES), IF ANY, AND IN THE EVENT OF MY DEATH, DESIGNATE THE FOLLOWING:

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 –

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 II - BENEFICIARY DESIGNATION INFORMATION - PRINCIPAL *(Continued)*

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 BENEFICIARYHDAYTIME TELEPHONE NUMBER (Include Area Code)

INSURANCE PAYMENT DISTRIBUTION

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

SECTION III - BENEFICIARY DESIGNATION INFORMATION - CONTINGENT

Contingent Beneficiaries are the person(s) or entity(ies) you choose to receive your life insurance proceeds if the principal beneficiary (ies) die or the entity dissolves before you die. **Payment will be made in equal shares unless otherwise specified.** In the event that a designated contingent beneficiary predeceases you, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

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

FIRST 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 ____

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 - BENEFICIARY DESIGNATION INFORMATION - CONTINGENT *(Continued)*

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

__ – __ – ____

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) ►** ☐

THIRD 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

__ – __ – ____

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 IV - 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 V - 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**