Prudential

Office of Servicemembers'
Group Life Insurance

Claim for Accelerated Benefits

Servicemembers' Group Life Insurance (SGLI)
Veterans' Group Life Insurance (VGLI)

About the Accelerated Benefit Option

The Accelerated Benefit Option allows you to receive up to 50% of your SGLI or VGLI benefit if you have been diagnosed by your physician as being terminally ill (as defined in Public Law 105-368) with nine (9) months or less to live. Only you (the insured) can apply for this benefit.

The amount of insurance proceeds payable to your beneficiaries at the time of your death will be reduced by the amount of accelerated benefit you choose to receive now. Your premium will be lowered to reflect your reduced coverage amount.

How to Submit a Claim for Accelerated Benefits

You, your physician and, if you're covered under SGLI, your branch of service must complete the attached forms as indicated. Completed forms should be submitted as follows:

Active duty service members/Reservists	Army National Guard	Veterans
Submit completed forms to your branch of service personnel office.	Contact your state headquarters for submission instructions.	Submit completed forms to: The Prudential Insurance Company of America PO Box 70173 Philadelphia, PA 19176-0173 Fax: 877-832-4943

Important Information

- If your claim for accelerated benefits is approved, you will receive a check for the amount requested.
- Once the payment is cashed, the accelerated benefit cannot be revoked.
- You can receive this benefit only once during your lifetime.
- You may use this benefit for any purpose you choose.
- If you're covered under SGLI, the Office of Servicemembers' Group Life Insurance (OSGLI) will notify your branch of service to reduce the face amount of your coverage and your premium rate.
- If you die before cashing the accelerated benefit check, your next of kin should return the check to OSGLI.
- If your claim is not approved, you have the option of submitting additional medical information or reapplying at a later date.

OMB Control No.: 2900-0618
Respondent Burden: 12 minutes
Expiration Date: xx/xx/xxxx

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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 38, Code of Federal Regulations 1.576 for routine uses identified in the 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 voluntary. VA uses your 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.

TO BE COMPLETED BY SERVICE MEMBER OR VETERAN

CLAIM FOR ACCELERATED BENEFITS

Name (first middle last)		**Social Security Number**
Home address	**Date of birth** (mm/dd/yyyy)	**Branch of Service** (if covered under SGLI)
Mailing address (if different from home address)	**Amount of SGLI/VGLI coverage** **$**	**Amount of claim** (Cannot exceed 50% of your total coverage) **$**
Telephone Number	**Email Address** (Your email address is being requested so that we can provide you with a tracking number once your claim has been processed)	

Type of coverage (check one)

- ☐ **VGLI**
- ☐ **SGLI** (if covered under SGLI, indicate your current status)
  - ☐ **Active Duty**
  - ☐ **Ready Reserve**
  - ☐ **Army or Air National Guard**
  - ☐ **Separated or Discharged**

Important: If you checked SGLI, your branch of service personnel office must complete page 4.

I acknowledge that I have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my coverage will reduce by the amount of accelerated benefit I choose to receive now.

Signature _____ Date Signed _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:

You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.

Print Name _____

Signature _____ Date Signed _____

A photocopy of this authorization will be considered as effective and valid as the original. Valid for one year from date signed.

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TO BE COMPLETED BY SERVICE MEMBER'S OR VETERAN'S PHYSICIAN

ATTENDING PHYSICIAN'S CERTIFICATION

Patient's name	**Patient's Social Security Number**

Diagnosis	**ICD-9-CM/ICD-10-CM Disease Code***

Description of Present Medical Condition (Please attach any supporting documentation such as x-rays, E.K.G. results, or test results.)

Do you feel the claimant is competent to endorse checks and direct the use of the proceeds. ☐ Yes ☐ No

The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement? ☐ Yes ☐ No

Attending physician's name (please print)	**State in which you are licensed to practice**	**Specialty**

Mailing address	**Fax number**	**Telephone number**

Signature _____ Date Signed _____

**International Classification of Diseases, 9th revision, Clinical Modification/International Classification of Diseases, 10th revision, Clinical Modification*

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TO BE COMPLETED BY THE PERSONNEL OFFICE OF THE SERVICE MEMBER'S UNIT

Complete only if the applicant for accelerated benefits has SGLI coverage.

BRANCH OF SERVICE STATEMENT

Service member's name	**Social Security Number**	**Branch of Service**
Amount of SGLI coverage **$** 250,000	**Monthly premium amount** **$**	
Name and title of person completing this form	**Telephone number**	**Fax number**
Duty station and address		

Signature of person completing this form _____ Date _____

Note: After completing this section, the personnel officer should submit the form to the service member's casualty branch.

TO BE COMPLETED BY THE SERVICE MEMBER'S CASUALTY BRANCH

Certified by:	
Name _____	**Title** _____
Branch of Service	**Certification date**
Telephone number	**Fax number**

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.