OMB Approved No. 2900-0016 Respondent Burden: 1 hour 45 minutes Expiration Date: XXXXXXXX

Department of Veterans Affairs

CLAIM FOR DISABILITY INSURANCE GOVERNMENT LIFE INSURANCE

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 Records - VA, published in the Federal Register. Your obligation to respond is required to obtain this benefit. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 VA insurance benefits. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 45 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 your comments or suggestions about this form.

INFORMATION AND INSTRUCTIONS

THIS APPLICATION IS TO BE COMPLETED BY VETERANS WHO HAVE GOVERNMENT LIFE INSURANCE AND BECOME TOTALLY DISABLED.

TOTAL DISABILITY:

- 1. Any impairment of mind or body which makes it impossible for the veteran to be gainfully employed.
- 2. Total Disability must start before the veteran's 65th birthday.

WAIVER REFUND

- 1. Premium Refunds limited to one year prior to date the claim is filed, unless there were circumstances beyond the veteran's control (such as a severe mental disability). LACK OF KNOWLEDGE OF THE WAIVER PROVISION IS NOT A CIRCUMSTANCE BEYOND THE VETERAN'S CONTROL.
- 2. If total disability started more than one year prior to the date of your claim, and you believe a mental disability prevented you from filing an earlier claim, please include a statement explaining these circumstances on a separate sheet of paper. YOU SHOULD ALSO INCLUDE ANY MEDICAL EVIDENCE WHICH SUPPORTS YOUR STATEMENT.

PART I should be completed by the insured veteran if able; if not, by a person acting on his/her behalf.

PART II should be completed by the insured veteran's physician or hospital official. If there will be a delay in preparing Part II send Part I immediately.

NOTE: IF THE VETERAN HAS BEEN GRANTED DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION, PLEASE ATTACH A COPY OF THE AWARD LETTER.

PART I							
1. FIRST, MIDDLE, LAST NAME OF INSURED (Type or print)	2. INSURANCE FILE NUMBER (Include letter prefix)						
3. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and Stree Route, City or P.O., State and ZIP Code)	et or Rural 4. SOCIAL SECURITY NUMBER						
	5. DATE OF BIRTH						
	6. DAYTIME TELEPHONE NUMBER (Include Area Code)						
	7. CLAIM NUMBER						
	7. CLAIM NOMBER						
8. DATE DISABILITY PREVENTED EMPLOYMENT	9. DATE RETURNED TO GAINFUL EMPLOYMENT						
10A. EDUCATION (Check highest years completed) (If you have any other special	alized training or education please complete Item 10B)						
	1 🔲 2 🖂 3 🖂 4 💢 🖂 1 🖂 2 🖂 3 🖂 4						
(Grade School)	(High School) (College)						
10B. PLEASE PROVIDE ANY SPECIALIZED TRAINING IN THE SPACE PR	ROVIDED BELOW						
11. ARE YOU RECEIVING OR HAVE YOU APPLIED FOR ANY	12. DISEASE OR INJURY CAUSING TOTAL OR PERMANENT DISABILITY						
DISABILITY BENEFITS AS LISTED BELOW?	12. DIGENGE GIVINGGIVI GAGGING TOTAL GIVT ENWANEIVI DIGADIETTI						
VA DISABILITY COMPENSATION □ VA PENSION □ SOCIAL SECURITY DISABILITY							

lF \			ESTIONS ABOUT DISAE E CALL OUR TOLL FREE			RINSUF	RANCE,	
	13. HOS	PITALS	WHERE YOU HAVE BEEN T	REATED, INCLU	DING VA HOSPI	TALS		
NAME OF HOSPITAL		ADDRESS OF HOSPITAL		ITAL	DATE OF ADMISSION		DATE OF RELEASE	
							-	
14. PHYSIC	IANS WHO HAV	 E TREA	TED YOU FOR DISEASE OR	INJURY. CAUSIN	 IG TOTAL PERN	/ANENT	DISABILITY	
				DATE TREATMENT		DATE OF LAST		
NAME OF PHYSICIAN		ADDRESS OF PHYSICIAN		BEGAN		TREATMENT		
15. RE0	CORD OF EMPLO	OYMEN	T FOR ONE YEAR PRIOR TO (Include self-em)		OTAL DISABILIT	Y TO TH	E PRESENT	
DATES OF E	MPLOYMENT	LAS	LAST DAY INSURED WORKED HOURS WO		ORKED EARNINGS			
FROM	то	DATE		WEEKLY		WEEKLY		
OCCUPATION		NAME AND ADDRESS OF EMPLOYER		REASON FOR TERMINATION OF EMPLOYMENT				
DATES OF EMPLOYMENT		LAS	ST DAY INSURED WORKED	ED WORKED HOURS WORKE		EARNINGS		
FROM	ТО	DATE		WEEKLY		WEEKLY		
OCCUPATION		NAME AND ADDRESS OF EMPLOYER		<u> </u>	REASON FOR TERMINATIO		ON OF EMPLOYMENT	
DATES OF EMPLOYMENT		LAST DAY INSURED WORKED		HOURS WORKED		EARNINGS		
FROM	ТО	DATE		WEEKLY	WEEKLY		WEEKLY	
OCCUPATION		NAME AND ADDRESS OF EMPLOYER		REASON FOR		TERMINATION OF EMPLOYMENT		
I consent that any physician or hospital who has treated or examined me for any purpose, or who I have consulted professionally, any insurance company or organization to which I have applied for insurance, or any person, persons, firm or corporation to whom, or to which I have applied for employment or disability benefits, may provide to the Department of Veterans Affairs or testify as to, or produce in court, any information obtained concerning myself by reason of the foregoing, and waive any privileges which render such information confidential. A photostatic copy of this consent shall be considered valid authorization for release of information to VA. I certify that each question has been truthfully and completely answered to the best of my knowledge.								
16. DATE OF SIGNATURE 17. SIGNATURE OF INSURED (Or official or fiduciary completing form for insured)								
PENALTY - The law provides that whomever makes any statement of a material fact, knowing it to be false, shall be punished by fine or imprisonment or both.								

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REPORT FOR DISABILITY INSURANCE PURPOSES OF TREATMENT IN A HOSPITAL OR FROM AN ATTENDING PHYSICIAN					PART II			
Part II of this applic hospital summaries	ation should be are available, p	completed by the approlease forward with apple	opriate hospication.	pital official	or by the veteran's	attending physician. If appropriate		
1. FIRST, MIDDLE, LAST NAME OF INSURED (Type or print)				2. INSURANC	2. INSURANCE FILE NUMBER (Include letter prefix)			
3. HOME ADDRESS (Number and Street o	or Rural Route, City or P.O., I	State and ZIP	Code)	F	FOR VA USE ONLY		
					4. CLAIM NUMBER	5. SOCIAL SECURITY NUMBER		
		6. HISTOI	RY (Condition	ons causing disal	bility)			
A. WHEN DID INJURY	OR ILLNESS BE	GIN?	В	B. DATE INSU	RED STOPPED WOR	RKING BECAUSE OF DISABILITY		
C. DATE OF FIRST TF	REATMENT	D. FREQUENCY AND N	ATURE OF	TREATMENT				
E. OBJECTIVE SYMP	TOMS AND FIND	 INGS WHEN FIRST SEEN	F. DIAC	GNOSIS, INCL	UDE RESULTS OF	SPECIAL STUDIES		
		7	7. HOSPITAI	LIZATION				
	TE	NAM	F AND ADD	RESS OF HO	SPITAI	CONDITION AT DISCHARGE		
FROM	ТО			11200 01 110		CONSTRUCTION TO SECTION TO SECTIO		
			8. PROGI	NOSIS				
A. DATE OF LAST EX	AM OR TREATME	ENT B. OBJECTIVE FIN	IDINGS					
C. DIAGNOSIS - CON	DITIONS CAUSIN	IG DISABILITY				D. IS VETERAN CAPABLE OF DOING ALL OF HIS/HER WORK? YES NO		
						E. IS VETERAN CAPABLE OF DOING ANY OTHER WORK?		
F. CARDIAC FUNCTION	ON (Check if application)	able)						
AHA FUNCTIONAL	CAPACITY - CL	1 (NO LIMITATION)			,	MARKED LIMITATION)		
		2 (SLIGHT LIMITATION)			· · · · · · · · · · · · · · · · · · ·	COMPLETE LIMITATION)		
interpersonal relations NO		/	l situations an IARKED	nd engage in SEVERI		RST TREATMENT HAS VETERAN REMAINED		
LIMITATION	LIMITATION		IMITATION	LIMITAT				
5. INAIVIE AND ADDICE	.33 OF ATTENDI	NG FITTSICIAN OILTIOSF	TIAL					
10. DATE OF REPOR	Г 1	1. SIGNATURE AND TITL	E OF PERS	ON PREPARI	NG REPORT			
When completed and maintained. The addre	signed, send this	claim form IMMEDIATELY nent of Veterans Affairs offi	to the office	of the Departr	ment of Veterans Affa cords is:	airs where the Insurance Records are		
The fastest and most Insurance is to use on https://insurance.va.	our document up	end documents to VA load service at		Regiona P.O. Bo	nent of Veterans Aff al Office and Insura x 7208 Iphia, PA 19101			

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