

# SERVICEMEMBERS' GROUP LIFE INSURANCE TRAUMATIC INJURY PROTECTION PROGRAM (TSGLI)

Administered by the Office of Servicemembers' Group Life Insurance

# Application for TSGLI Benefits

Please submit your completed claim to your branch of service below.

		<b>TSGLI Branch of Se</b>	rvice Contacts	
Branch	Contact Information	Submit Claim by Fax	Submit Claim by Email	Submit Claim by Postal Mail
<b>Army</b> All Components	Phone: 888-276-9472 Website: <u>www.hrc.army.mil/content/</u> <u>Traumatic Servicemembers' Group Life</u> <u>Insurance</u>	502-613-4513	usarmy.knox.hrc.mbx.tagd-tsgli-claims @mail.mil	US Army Human Resources Command 1600 Spearhead Division Avenue, Dept 420 PDR-C (TSGLI) Fort Knox, KY 40122-5402
Marine Corps All Components	Phone: 877-216-0825 or 703-975-4069 Website: <u>www.woundedwarrior.marines.mil</u>	800-770-9968	t-sgli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Street Quantico, VA 22134
<b>Navy</b> All Components	Phone: 1-877-270-2162 Website: <u>www.mynavyhr.navy.mil/</u> <u>Support-Services/Casualty/TSGLI/</u>	901-874-2265	MILL_TSGLI.FCT@navy.mil	Commander, Navy Personnel Command Attn: PERS-00C 5720 Integrity Drive Millington, TN 38055-1300
Air Force and Space Force Active Duty	Phone: 800-525-0102, Option 1, Option 1		AFPC.DPFCS.Pol_Trng_CaseMgt@ us.af.mil	AFPC/DPFCS 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716
Air Force Reserves and Air National Guard	Phone: 800-525-0102, Option 3, Option 1	720-847-3887	casualty.arpc1@us.af.mil	HQ, ARPC/DPTTB 18420 E. Silver Creek Ave. Building 390 MS 68 Buckley AFB, CO 80011
Coast Guard	Phone: 202-795-6638 Website: <u>www.dcms.uscg.mil/PSD/fs/TSGLI</u>		ARL-PF-CGPSC-PSDFS- COMPENSATION@uscg.mil	Commander (CG) Personnel Service Center (PSC) Attn: TSGLI Case Manager, PSC-PSD-FS-Casualty U.S. Coast Guard STOP 7200 2703 Martin Luther King Jr Ave SE Washington, DC 20593-7200
Public Health Service	Phone: 240-276-8799	240-276-8817 or 240-453-6030	compensationbranch@psc.hhs.gov	PHS Compensation Branch 1101 Wootton Parkway Suite: 100 Rockville, MD 20852
NOAA Corps	Phone: 301-713-3444	301-713-4140	Director.cpc@noaa.gov	U.S. Dept. of Commerce NOAA/OMAO/CPC 8403 Colesville Rd, Suite 500, 5th Floor Silver Spring, MD 20910



# **GENERAL INFORMATION**

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program provides for payment to service members who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured service members and their families with financial burdens associated with recovering from a severe injury. TSGLI payments range from \$25,000 to \$100,000, based on the qualifying loss suffered.

# WHO IS ELIGIBLE?

Effective December 1, 2005, all service members who are insured under SGLI and:

- experience a traumatic event
- that results in a traumatic injury
- which is listed as a qualifying loss

are eligible to receive a TSGLI payment. Service members who were severely injured between October 7, 2001 and November 30, 2005 may also be eligible for a TSGLI payment, regardless of where their injury occurred or whether they had SGLI coverage at the time of their injury. Members should contact their branch of service for more information.

### What is a Traumatic Event?

A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

#### What is a Traumatic Injury?

A traumatic injury is the physical damage to your body that results from a traumatic event.

### What is a Qualifying Loss?

A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses, which lists all covered losses and payment amounts. You may view the complete Schedule of Losses and other TSGLI information at http://www.benefits.va.gov/insurance/tsgli\_schedule\_Schedule.asp. Your branch of service TSGLI office will determine whether your injury is a qualifying loss for TSGLI purposes.

# HOW TO FILE A TSGLI CLAIM

Filing a TSGLI claim is a three-step process in which the service member [or guardian, power of attorney or military trustee] and a medical professional must complete and submit the appropriate parts of the TSGLI Claim Form as follows:

Step 1	Step 2	Step 3
The service member [or guardian, power of attorney or military trustee]	The medical professional	The medical professional OR the service member [or guardian, power of attorney or military trustee]
must complete Part A (pages 3 through 7) of the form and give it to a medical professional to complete Part B. Note: If a guardian or power of attorney completes Part A, they must include copies of letters of guardianship, letters of conservatorship, power of attorney, or durable power of attorney (if appropriate).	must complete Part B.	must forward Parts A and B, along with medical records that document the member's injury and resulting loss, to the member's branch of service TSGLI office listed on the front cover of this form.

# **COMPLETING THE FORM**

Instructions on completing the TSGLI Claim Form are included in each section. When completing the form, the service member, guardian, power of attorney or military trustee **must** complete the service member's Social Security number on each page of the form. If you have questions about completing the form or if the member is deceased, please contact the branch of service TSGLI office listed on the front cover of this form.

# CLAIM DECISION AND PAYMENT

# Who Makes the Decision on My Claim?

Your branch of service TSGLI office will make the decision on your claim based upon the information in Parts A and B of the TSGLI Claim Form and any supporting medical documentation you provide. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.



### Who Will Receive the TSGLI Payment?

Payment will be made directly to the member. If the member is unable, payment will be made under the appropriate letters of guardianship/ conservatorship or a power of attorney to the guardian, power of attorney or military trustee on the member's behalf. If the member dies after qualifying for payment, the payment will be made to the member's current listed SGLI beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

#### How the TSGLI Payment Will Be Made?

If your branch of service TSGLI office approves your claim, OSGLI will make the TSGLI benefit payment. There are three payment methods used for TSGLI benefits: Prudential's Alliance Account<sup>®</sup>,\* Electronic Funds Transfer (EFT), or check. If you do not choose a payment option, OSGLI will make the payment through Prudential's Alliance Account.

#### 1. Prudential's Alliance Account\*

- The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time, subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.
- 2) The interest rate credited to the Alliance Account is adjusted by Prudential at its discretion based on variable economic factors (including, but not limited to, prevailing market rates for short-term demand deposit accounts, bank money market rates and Federal Reserve Interest rates) and may be more or less than the rate Prudential earns on the funds in the account.
- 3) An Alliance Account is an interest bearing draft account established in the beneficiary's name with a draft book. The beneficiary can write drafts for any amount up to the full amount of the proceeds. There are no monthly service fees or per draft charges and additional drafts can be ordered at no cost, but fees apply for some special services including returned drafts, stop payment orders and copies of statements/drafts.
- 4) The funds in your Alliance Account are available immediately. Use the drafts to access the account anytime you wish. You can write a draft to yourself (which you can cash or deposit at your own bank) or write a draft to another person, or to any business as you need your funds.
- 5) Alliance Account funds are part of Prudential's General Account and are backed by the financial strength of The Prudential Insurance Company of America which has been in business and serving its customers for over 140 years. The Alliance Account is not a bank account or a bank product, and therefore, is not FDIC insured.
- 6) Account holders cannot make deposits into an Alliance Account. Only eligible payments from other Prudential insurance policies or contracts may be added to the Alliance Account.

**Note:** A service member's legal guardian, military trustee, or power of attorney (POA) may choose the Alliance Account payment option as long as they submit proof of that appointment (i.e., the appropriate documentation) with the claim. The guardian, military trustee, or POA will not have their name added to the account, but will be able to sign Alliance Account drafts on behalf of the member.

- 2. Electronic Funds Transfer (EFT) Your bank account will be electronically credited with the TSGLI payment amount. Depending on your bank, payments will be credited three to five days from the date the payment is authorized.
- 3. Check Payment A check will be issued to the service member, guardian, power of attorney or military trustee on behalf of the member.



<sup>\*</sup> The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC)**. The Bank of New York Mellon is not a Prudential Financial company.

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### 3 Traumatic Injury Information

#### Injuries that Qualify for TSGLI Payment

To qualify for the TSGLI benefit, you must have experienced a **traumatic event** that resulted in a **traumatic injury** that is listed as a **qualifying loss** on the TSGLI Schedule of Losses.

#### **Definitions:**

**Traumatic Event** — A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to your body.

**Traumatic Injury** — A traumatic injury is the physical damage to your body that resulted from a traumatic event (illness or disease is not covered).

**Qualifying Loss** — A qualifying loss is a traumatic injury that is listed on the TSGLI Schedule of Losses. See the complete Schedule of Losses at http://www.benefits.va.gov/insurance/tsgli\_schedule\_Schedule\_asp.



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Fraumatic njury nformation	Information About Your Loss Is the loss you are claiming the result of any of the following: a. an intentionally self-inflicted injury or an attempt to inflict such injury?	🗌 Yes	🗌 No
	b. use of an illegal or controlled substance that was not administered or consumed on the advice of a medical doctor?	🗌 Yes	🗌 No
	c. the medical or surgical treatment of an illness or disease?	Yes	No No
	d. a traumatic injury sustained while committing or attempting to commit a felony?	🗌 Yes	🗌 No
	e. a physical or mental illness or disease (not including illness or disease caused by a wound infection, a chemical, biological, or radiological weapon, or the accidental ingestion of a contaminated substance)?	🗌 Yes	🗌 No
	<b>If you answered yes</b> to any of the questions above, you are not eligible for a TSGLI payment and should not file a claim.		
	<b>If you are not sure</b> whether your loss is a result of one of the items above, please contact your Branch of Service TSGLI if you are eligible.	Office to fin	d out
	<b>Tell us about your traumatic Injury</b> 1. Were you covered under Servicemembers' Group Life Insurance (SGLI) at the time of the injury?	Yes [	□ No
	<ol> <li>In the box below, please describe your injury and give the date, time and location where it occurre medical records with this claim that document your injuries and resulting loss. (See Part</li> </ol>		
	Traumatic Injury Information		
	Traumatic Injury Information		



Service member's Social Security number										

Payment Options Please choose one of the three payment options by checking the appropriate box and filling in the requested information. Payment Option 1 – Prudential's	<b>Payment Opti</b> Complete the ma	of the three paymen on 1 - Prudential's A iiling address below (st ng Address for Payment -	Illiance Account treet address only, no P.O. b	boxes).	Apartment, Ward o	or Room (if any)
Alliance Account An interest-bearing account will be established in the name of the member, who can access the money using the draft book. A guardian, power of attorney, or military trustee may sign Alliance Account drafts on behalf of the member if proof of appointment is submitted with the claim.		•	Inds Transfer (EFT)         your banking information b         Account Number         Image: Image of the second seco		ank Phone Number	Checking
Payment Option 2 – Electronic Funds Transfer This option can be selected by member or, if applicable, the guardian, power of attorney or military trustee. Payment will be made to the service member's bank account. Payment Option 3 – Check	The <b>bank routing</b> <b>number</b> is always 9 digits and appears between the <b>:</b> symbols	Customer XYZ XYZ Street City, State, ZIP PAY TO THE ORDER OF Bank XYZ UXYZ Street City, State, ZIP A27202754 Bank Routing Number	Sample Che 006666D66666C	2CK 1246 Check Number	Check No. 1246\$Dollars	The <b>bank account</b> <b>number</b> varies in length and may contain dashes or spaces. The 11= symbol indicates the end of the account number.
A check will be issued to the service member, guardian, power of attorney or military trustee on behalf of the service member.	Payment Option     Important: If you     when requesting     Mailing Address for Pay     City	are a guardian, powe I a check.	r of attorney or military tru:	Istee you must col	Apartment (if any)	
Financial Counseling VA sponsors financial counseling for TSGLI recipients.	You should get financial	ceive financial counse counseling as soon as po	eling with my TSGLI benefit assible after receiving your ins www.benefits.va.gov/insura	surance money and	before making any m	ajor financial decisions.



Service member's Social Se	curity number	
6 Signature	X	
	Signature of service member, guardian, power of attorney or military trustee Date Signed (mm/dd/yyyy)	Description of Authority to
	<b>WARNING.</b> Any intentional larse statement in this claim of winnut inistepresentation relative thereto is subject to	act on behalf of the member (Guardian, POA, etc.)

Description of Authority: If the guardian, power of attorney or military trustee completes this section, they must also indicate their authority to act on behalf of the member (e.g., guardian, conservator, etc.).

# Member must complete and sign the HIPAA release on page 7



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Authorization
for Release of
Information to
Branch of Service
and Office of
Servicemembers'
Group Life
Insurance

The member, guardian, power of attorney, or military trustee **must** complete and sign this section.

#### Failure to complete this section will delay payment of claim.

This Authorization is intended to comply with the HIPAA Privacy Rule.

#### Member must complete and sign the HIPAA release below:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

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or on my behalf ("My Providers") to disclose my entire medical record for me or my dependents and any other health information concerning me to the Branch of Service and Office of Servicemembers' Group Life Insurance (OSGLI) and its agents, employees, and representatives. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. OSGLI is an administrative unit created by Prudential to administer the Servicemembers' Group Life Insurance Program. OSGLI administers the TSGLI program on behalf of the Department of Veterans Affairs.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits\* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) administer coverage, and 3) conduct other legally permissible activities that relate to any coverage I have applied for with OSGLI.

This Authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 80 Livingston Avenue, Roseland, NJ 07068. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

\*Limits, if any:

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NOTE: This release authorizes the branch of service and OSGLI to look at medical records. You may also be asked to provide these documents.

# Signature

The member, guardian, power of attorney or military trustee must sign here.

Signature of service member	, guardian	, power of attorney	or military trustee



Description of Authority to act on behalf of the member (Guardian, POA, etc.)



**PART B - Medical Professional's Statement -** to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Sec			
<b>1</b> Patient Information	Patient's First Name   Date of Injury (mm/dd/yyyy)   If patient is deceased, please provide:   Date of Death (mm/dd/yyyy)   Cause of Death	MI Patient's Last Name	
2 Qualifying Losses Suffered by Patient	Inpatient hospitalization is defined as: "Being hospitalized Definition of a hospital – A hospital that is accredited as a hose Accreditation of Healthcare Organizations. This includes Combat Hospital does not include a nursing home. Neither does it include	spital under the Hospital Accreditation P Support Hospitals, Air Force Theater Ho	rogram of the Joint Commission on spitals and Navy Hospital Ships.
Instructions: Please check the box next to each loss the patient has experienced and fill in any additional information requested. Omitted information, such as sight or hearing measurements, will delay processing of the claim. Patient's loss MUST meet the definition of loss given.	Prospiral does not include a nursing nome. Nemier does it include convalescence, rest, nursing care or for the aged; or (2) furnishes or (3) is for residential or domiciliary living; or (4) is mainly a schowing that the member hospitalized as an inpatient for at least 15 content in the set of the age age of the age of the age of the age of the age of t	s mainly homelike or Custodial Care, or the col. secutive days? Yes I repredominant reason the patient wathing and ending dates for the lon ve inpatient hospitalization days begins to tinues through subsequent transfers from m/dd/yyyy) Date of discharge	aining in the routines of daily living; No s hospitalized. gest period of consecutive days the when the injured member is transported n one hospital to another, and includes
	Loss of Sight is defined as:	Loss of Sight	Date of onset/loss (mm/dd/yyyy)
	<ul> <li>Visual acuity in at least one eye of 20/200 or less (worse) with corrective lenses, OR</li> </ul>	Loss of sight in left eye or anatomical loss of left eye	
	<ul> <li>Visual acuity in at least one eye of greater (better) than 20/200 with corrective lenses and a visual field of 20 degrees or less, OR</li> <li>Anatomical loss of eye. Loss of sight must be expected to be permanent OR must have lasted at least 120 days.</li> </ul>	Loss of sight in right eye or anatomical loss of right eye Visual Acuity and Field Best corrected visual acuity	Left Eye Right Eye
		Visual Field (degrees)	
	Loss of Speech is defined as: An organic loss of speech (lost the ability to express oneself, both by voice and by whisper, through normal organs for speech). If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.	Loss of Speech	Date of onset (mm/dd/yyyy)



**PART B** - **Medical Professional's Statement (cont'd)** - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Service member's Social Security number 2 Qualifying Loss of hearing is defined as: Loss of Hearing Date of onset (mm/dd/yyyy) Losses Average hearing threshold sensitivity for air conduction of Loss of hearing in left ear Suffered by at least 80 decibels. Hearing Acuity must be measured at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing Patient (cont'd) threshold. Loss of hearing must be clinically stable and Loss of hearing in right ear unlikely to improve. Left Ear **Hearing Acuity Right Ear** Average Hearing Acuity (measured db db without amplification device) Burns are defined as: Burns 2nd degree (partial thickness) or worse burns over 20% of the 2nd degree or worse burns to the body including face and head body including the face and head OR 20% of the face only. 2nd degree or worse burns to the face only Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative. Percentage of Percentage of body affected % face affected % Coma is defined as: Coma Coma with brain injury measured at a Glasgow Coma Score Coma of 8 or less that lasts for 15, 30, 60 or 90 consecutive days. Date of onset (mm/dd/yyyy) Date of recovery (mm/dd/yyyy) Number of days includes the date the coma began and the date the member recovered from the coma. **OR** Check here if coma is ongoing Glasgow score at 30 days Glasgow score at 60 days Glasgow score at 90 days Glasgow score at 15 days Important: Facial Reconstruction is defined as: **Facial Reconstruction** Facial Reconstructive surgery to correct traumatic avulsions of the Upper or lower jaw 50% of left zygomatic face or jaw that cause discontinuity defects, specifically **Reconstruction:** If the patient is surgery to correct discontinuity loss of the following: 50% of cartilaginous nose 50% of right zygomatic undergoing facial upper or lower jaw 50% of upper lip 50% of left mandibular reconstruction, a ■ 50% or more of the cartilaginous nose surgeon MUST 50% of lower lip 50% of right mandibular ■ 50% or more of the upper or lower lip certify this section by checking the box, 30% or more of the periorbital 30% of left periorbital 50% of left infraorbital printing his/her name ■ tissue in 50% or more of any of the following facial 30% of right periorbital 50% of right infraorbital and signing on the subunits: forehead, temple, zygomatic, mandibular, appropriate line. infraorbital or chin 50% of left temple 50% of chin 50% of right temple 50% of forehead **Certification of Surgeon** Date of first surgery (mm/dd/yyyy) First Name of Surgeon Last Name of Surgeon Forehead Temple Specialty Periorbital Date Signed (mm/dd/yyyy) Zygomatic Infraorbital Х Upper lip Signature of Surgeon Lower lip Telephone Number Mandibular Chin

3 2 6

PART B - Medical Professional's Statement (cont'd) - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Qualifying Losses	<b>Amputation is:</b> the severance or removal of a limb or genital organ or p traumatic injury, or surgical removal that is required for the treatment of		ling both severance due to a
Suffered by Patient (cont'd)	Amputation of Hand is defined as:	Amputation of Hand	Date of amputation (mm/dd/y
	Amputation of hand at or above the wrist.	Amputation of left hand	
	Above the wrist means closer to the body.	Amputation of right hand	
	Amputation of Fingers is defined as:	Amputation of Fingers	Date of amputation (mm/dd/y
	<ul> <li>Amputation of four fingers on the same hand (not including the thumb) at or above the</li> </ul>	Amputation of 4 fingers/ left hand	
	metacarpophalangeal joint, OR	Amputation of 4 fingers/ right hand	
	the metacarpophalangeal joint.	Amputation of left thumb	
	means closer to the body.	Amputation of right thumb	
	Amputation of Foot is defined as:	Amputation of Foot	Date of amputation (mm/dd/y
	<ul> <li>Amputation of foot at or above the ankle, OR</li> <li>Amputation of all toes (including the big toe) on the</li> </ul>	Amputation of left foot	
	same foot at or above the metatarsophalangeal joint. Above the ankle and above the metatarsophalangeal joint means closer to the body.	Amputation of right foot	
	Amputation of Toes is defined as:	Amputation of Toes	Date of amputation (mm/dd/y
	<ul> <li>Amputation of four toes on one foot at or above the</li> </ul>	Amputation of 4 toes/ left foot	
	metatarsophalangeal joint (not including the big toe), OR	Amputation of 4 toes/ right foot	
	<ul> <li>Amputation of big toe at or above the metatarsophalangeal joint.</li> </ul>	Amputation of big toe/ left foot	
	Above the metatarsophalangeal joint means closer to the body.	Amputation of big toe/ right foot	
Important:	Limb Salvage is defined as:	Limb Salvage	Date of first surgery (mm/dd/y
Limb Salvage: If the patient is	A series of operations designed to avoid amputation of an arm or a leg while at the same time maximizing the limb's	Salvage of left arm	
undergoing limb salvage, a surgeon MUST certify this	functionality. The surgeries typically involve bone and skin grafts, bone resection, reconstructive, and plastic surgeries and often occur over a period of months or years.	Salvage of left leg	
section by printing his/her name and	Submit operative report for each surgery.	Salvage of right arm	
signing on the		Salvage of right leg	
appropriate line.	Certification of Surgeon		
	I certify that the patient is undergoing limb salvage surgery as defined in the column to the right.	Additional Comments	
	First Name of Surgeon Last Name of Surgeon		
	Specialty		
	Date Signed (mm/dd/yyyy)	Telephone Number	
	X Signature of Surgeon		

PART B - Medical Professional's Statement (cont'd) - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

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<sup>2</sup> Qualifying	Paralysis is defined as:	Paralysis	Date of onset (mm/dd/yyyy)
Losses Suffered by Patient (cont'd)	Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain. A limb is defined as an arm or a leg with all its parts. Paralysis must fall into one of the four categories listed below:	Quadriplegia	
	<ul> <li>Quadriplegia - paralysis of all four limbs</li> </ul>		
	<ul> <li>Paraplegia - paralysis of both lower limbs</li> </ul>	Hemiplegia	
	<ul> <li>Hemiplegia - paralysis of the upper and lower limbs on</li> </ul>		
	one side of the body	Uniplegia	
	<ul> <li>Uniplegia - paralysis of one limb</li> </ul>		
	Anatomical loss of the penis is defined as:	Genitourinary System Losses	
	Amputation of the glans penis or any portion of the shaft of the penis above the glans penis or damage to the glans penis or shaft of the penis that requires reconstructive surgery.	Anatomical loss of the penis	Date of loss or amputation (mm/dd/yyyy
	Above the glans penis means closer to the body.		
	Permanent loss of use of the penis is defined as:	Permanent loss of	Date of loss (mm/dd/yyyy)
	Damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.	use of the penis	
	Anatomical loss of one testicle is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yyyy
	The amputation of, or damage to, one testicle that requires testicular salvage, reconstructive surgery, or both.	one testicle	
	Anatomical loss of both testicle(s) is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yyyy
	The amputation of, or damage to, both testicles that requires testicular salvage, reconstructive surgery, or both.	both testicles	
	Permanent loss of use of both testicles is defined as:	Permanent loss of	Date of loss (mm/dd/yyyy)
	Damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.	use of both testicles	
	Anatomical loss of the vulva is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yyyy
	The complete or partial amputation of the vulva or damage to the vulva that requires reconstructive surgery.	Left the vulva	
	Anatomical loss of the uterus is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yyyy
	The complete or partial amputation of the uterus or damage to the uterus that requires reconstructive surgery.	L the uterus	
	Anatomical loss of the vaginal canal is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yyyy
	The complete or partial amputation of the vaginal canal or damage to the vaginal canal that requires reconstructive surgery.	└──┘ the vaginal canal	
	Permanent loss of use of the vulva is defined as:	Permanent loss of	Date of loss (mm/dd/yyyy)
	Damage to the vulva that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.	use of the vulva	
	Permanent loss of use of the vaginal canal is defined as:	Permanent loss of use	Date of loss (mm/dd/yyyy)
	Damage to the vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.	└── of the vaginal canal	



# PART B - Medical Professional's Statement (cont'd) - to be completed by a medical professional who is a licensed practitioner of the backing arts acting within the scope of his/her practice

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Qualifying Losses Suffered by Patient (cont'd)	Anatomical loss of the ovary is defined as:	Anatomical loss of	Date of loss or amputation (mm/dd/yy
	The amputation of one ovary or damage to one ovary that requires ovarian salvage, reconstructive surgery, or both.	one ovary	
	Anatomical loss of both ovaries is defined as:	Anatomical loss of both ovaries	Date of loss or amputation (mm/dd/y)
	The amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both.		
	Permanent loss of use of both ovaries is defined as:	Permanent loss of use of both ovaries	Date of loss (mm/dd/yyyy)
	Damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.		
	Total and permanent loss of urinary system function is defined as:	Total and permanent loss of urinary system function	Date of loss (mm/dd/yyyy)
	Damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.		
Description	Inability to Independently Perform Activities of I	Daily Living (ADL)	
of Injury/ Assistance Needed Please provide a	Inability to Independently Perform ADL is defined as: Inability to independently perform at least two of six ADL (bathing for at least 15 consecutive days for traumatic brain injury and at le		
description of the injury and descriptions of the	The patient is considered unable to perform an activity independent patient is able to perform the activity by using accommodating equable to independently perform the activity without requiring assist	ntly only if he or she <b>REQUIRES</b> assistan upment, such as a cane, walker, commod	nce to perform the activity. If the
assistance needed to	Requires Assistance is defined as:	ance.	
perform each ADL. Failure to provide this	<ul> <li>physical assistance (hands-on),</li> </ul>		
information may delay	<ul> <li>standby assistance (within arm's reach),</li> </ul>		
processing of claim. What is the predominant reason	<ul> <li>verbal assistance (must be instructed because of cognitive im without which the patient would be INCAPABLE of performi</li> </ul>		
the patient is/was	What is the predominant reason the patient is/was unable t	to independently perform ADL?	
unable to independently	Traumatic Brain Injury Other Traumatic Injury		
perform ADL?	(Please describe injury and give reason(s) it resulted in inability to	perform activities of daily living.)	
Check the predominant reason			
the patient cannot			
independently perform ADL and			
describe the injury in			
the box provided.			

# PART B - Medical Professional's Statement (cont'd) - to be completed by a medical professional who is a licensed practitioner of the

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Qualifying Losses Suffered by	Patient is UNABLE to bathe independently if He/she requires assistance from another person to bathe			
Patient (cont'd)	(including sponge bath) more than one part of the body or get in or out of the tub or shower.			
<ul> <li>Which ADL is the patient unable to perform?</li> <li>Check each ADL the patient cannot perform;</li> <li>AND</li> <li>Fill in the dates inability began and ended or indicate inability is ongoing.</li> <li>Require Assistance is defined as:</li> <li>physical assistance (hands-on),</li> <li>standby assistance (within arm's reach),</li> <li>verbal assistance (must be instructed because of cognitive impairment),</li> <li>without which the patient would be INCAPABLE of performing the task.</li> </ul>	Describe assistance needed:  Patient is UNABLE to maintain continence independently if He/she is partially or totally unable to control bowel and bladder function or requires assistance from another person to manage catheter or colostomy bag. Describe assistance needed:	OR       Check here if inability is ongoing         Type of assistance required (check all that apply)         physical assistance (hands-on)       verbal assistance (must be instructed because of cognitive impairment)         standby assistance (within arm's reach)       End date (mm/dd/yyyy)         Lumble to maintain continence independently         Start date (mm/dd/yyyy)       End date (mm/dd/yyyy)         OR       Check here if inability is ongoing         Type of assistance required (check all that apply)       physical assistance (hands-on)         physical assistance (hands-on)       verbal assistance (must be instructed because of cognitive impairment)         within arm's reach)       cognitive impairment)		
	Patient is UNABLE to dress independently if He/she requires assistance from another person to get and put on clothing, socks or shoes. Describe assistance needed:	Unable to dress independently         Start date (mm/dd/yyyy)         End date (mm/dd/yyyy)         End date (mm/dd/yyyy)         OR       Check here if inability is ongoing         Type of assistance required (check all that apply)         physical assistance (hands-on)       verbal assistance (must be instructed because of cognitive impairment)		
	Patient is UNABLE to eat independently if         He/she requires assistance from another person to: <ul> <li>get food from plate to mouth, OR</li> <li>take liquid nourishment from a straw or cup, OR</li> <li>he/she is fed intravenously or by a feeding tube.</li> </ul> Describe assistance needed:	Unable to eat independently         Start date (mm/dd/yyyy)         End date (mm/dd/yyyy)         End date (mm/dd/yyyy)         OR       Check here if inability is ongoing         Type of assistance required (check all that apply)         physical assistance (hands-on)       verbal assistance (must be instructed because of cognitive impairment)		



**PART B** - **Medical Professional's Statement (cont'd)** - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

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1	Inability to Independently Perform Activities of Daily Living (ADL) (cont'd)		
Losses Suffered by Patient (cont'd)	Patient is UNABLE to toilet independently if	Unable to toilet independently	
	He/she must use a bedpan or urinal to toilet, OR	Start date (mm/dd/yyyy) End date (mm/dd/yyyy)	
	he/she <b>requires</b> assistance from another person with any of the following: going to and from the toilet, getting on and off the toilet, cleaning self after toileting, getting clothing off	OR Check here if inability is ongoing	
	and on.		
	Describe assistance needed:	Type of assistance required (check all that apply)	
		physical assistance (hands-on) verbal assistance (must be	
		standby assistance instructed because of cognitive impairment)	
	Patient is UNABLE to transfer independently if	Unable to transfer independently	
	He/she <b>requires</b> assistance from another person to move into or out of a bed or chair.	Start date (mm/dd/yyyy) End date (mm/dd/yyyy)	
	Describe assistance needed:		
		<b>OR</b> Check here if inability is ongoing	
		Type of assistance required (check all that apply)	
		physical assistance (hands-on) verbal assistance (must be	
		instructed because of	
		(within arm's reach) cognitive impairment)	
Information	<ul> <li>a. an intentionally self-inflicted injury or an attempt to inflict su</li> <li>b. use of an illegal or controlled substance that was not admin</li> <li>c. the medical or surgical treatment of an illness or disease,</li> <li>d. a physical or mental illness or disease (not including illness weapon, or the accidental ingestion of a contaminated subs</li> </ul>	istered or consumed on the advice of a medical doctor, or disease caused by a pyogenic infection, a chemical, biological, or radiolog	
	If yes, please explain below:		



**PART B** - **Medical Professional's Statement (cont'd)** - to be completed by a medical professional who is a licensed practitioner of the healing arts acting within the scope of his/her practice.

Medical Professional's Information       Name of Medical Professional First Name       Mi       Last Name         Medical Professional's Address (number and street)       Suite       Suite         Medical Professional's Address (number and street)       Suite         City       State       ZIP Code         Image: Description Number       Fax Number         Telephone Number       Fax Number         Specialty       Medical Degree         Medical Professional's License number       Medical Degree         Medical Professional's License number       Image: Description Number         Image: Description Number       Image: Description Number         Specialty       Medical Degree         Image: Description Number       Image: Description Number         Specialty       Medical Professional's License number         Image: Description Number       Image: Description Number         Image: Description Number       Image: Descrinthy Number	Service member's Social Se	curity number
Image: Second	Professional's	MI     Last Name       Mi     Last Name       Medical Professional's Address (number and street)     Suite
Image: Special ty		
6       Medical Professional's Signature       I have been directly involved in the patient's care for his/her loss.         I have not treated the patient for his/her loss but I have reviewed the patient's medical records.         Do you feel the claimant is competent to endorse checks and direct the use of the proceeds?       Yes       No         This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical		
Image: Neutron of the proceeds?       I have been directly involved in the patient's care for his/her loss.         Professional's Signature       I have not treated the patient for his/her loss but I have reviewed the patient's medical records.         Do you feel the claimant is competent to endorse checks and direct the use of the proceeds?       I yes         This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical		Medical Professional's License number
This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical	Professional's	I have not treated the patient for his/her loss but I have reviewed the patient's medical records.
Date (mm/dd/yyyy)		This Medical Professional's Statement is based upon my examination of the patient, and/or, a review of pertinent medical evidence. I understand the patient and/or I may be asked to provide supporting documentation to validate eligibility under the law.
X       Image: Signature         WARNING: Any intentionally false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than \$10,000 or imprisonment of not more than five years, or both. (18 U.S.C. 1001)		Signature WARNING: Any intentionally false statement in this claim or willful misrepresentation relative thereto is subject to punishment

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 (i.e., use by VA employees and your authorized representatives in the maintenance of Government Insurance programs) 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, but your failure to provide us the information could impede processing. No insurance may be granted unless a completed application form has been received (38 U.S.C. 2106 and 38 CFR 8a3(e)). 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. The responses you submit are considered considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information to determine, establish or verify 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 15 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 Intermet 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.

