OMB Control No. 2900-0919
Respondent Burden: 10 hours
Expiration Date: 7/31/2023

Department of Veterans Affairs

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

Administered by the Office of Servicemembers' Group Life Insurance

TSGLI Appeal Request Form

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

TSGLI Branch of Service Contacts

Branch	Contact Information	Submit Claim by Fax	Submit Claim by Email	Submit Claim by Postal Mail
Army All Components	Phone: 888-276-9472, Option 1 Website: www.hrc.army.mil/content/Traumatic Servicemembers' Group Life Insurance	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: www.woundedwarrior.marines.mil	800-770-9968	t-sgli@usmc.mil	HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Avenue Quantico, VA 22134
Navy All Components	Phone: 1-877-270-2162 Website: www.mynavyhr.navy.mil/Support-Services/Casualty/TSGLI/	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 Joint Base San Antonio - Randolph, TX 78150-4716
Air Force Reserves and Air National Guard	Phone: 800-525-0102, Option 3, Option 1		arpc.dpt.casualty@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: www.dcms.uscg.mil/PSD/fs/TSGLI		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 2700 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 Silver Spring, MD 20910

TSGLI APPEAL REQUEST FORM

Instructions

Use this form when filing an appeal for previously denied benefits under the Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program. Requests must be submitted to your branch's TSGLI office or Appeal office within one year of a claim's denial date. Please review your previous decision letter for instructions on where to submit your appeal and whether this form is required.

If you are submitting a new claim or claiming losses that were not previously reviewed, an Application for TSGLI Benefits (SGLV-8600) needs to be completed.

Who Makes the Decision on My Appeal?

Your branch of service TSGLI office, or its higher appeal authority, will make the decision on your appeal based upon the information provided on this form and any supporting documentation you provide. They will then forward their decision to the Office of Servicemembers' Group Life Insurance (OSGLI) for appropriate action.

1. First Name | MI | Last Name

2. SSN (Last 4 digits) | Date of Birth (MM DD YYYY)

3. Address: Street or PO Box

City | State | ZIP Code

4. Phone Number | Email Address

5. Date of traumatic event/injury (MM DD YYYY) | Location

6. List losses from TSGLI Schedule of Losses that are being appealed.

Third-Party Authorization

☐ (Optional) I authorize the following person to speak with OSGLI or the Branch of Service about my claim (this can be a spouse, parent, friend, or another person who is helping you with your claim).

First Name | MI | Last Name

Guardian, Power of Attorney, or Military Trustee Information

Important Note: Please include copies of the letters of guardianship, conservatorship, Power of Attorney, or DD Form 2827 – Application for Trusteeship etc. with this form. Failure to include this documentation will delay processing of your appeal.

Complete this section ONLY if a guardian, power of attorney, or military trustee will receive payment on behalf of the member.

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

7. Reason for appeal: Please check the box(es) that explain the reason(s) for your appeal. After each selected reason please provide a brief description of any new supporting evidence (Example: specific page number(s) in medical records, date(s) of medical records, police report, supporting statements etc.).

NOTE: To avoid delays in the review process, please highlight any new and material evidence within medical records and submit only the new evidence/documentation that supports the appeal. There is no need to resubmit all previously submitted documents as they will be considered when your appeal is reviewed.

To support my appeal, I am providing new evidence or documentation to support: (check all that apply):

☐ SGLI coverage was in effect at the time of the traumatic event.
Description of new evidence: _____

☐ New medical evidence to support my loss.
Description of new evidence: _____

☐ My loss occurred within 730 days of the traumatic event.
Description of new evidence: _____

☐ My loss was not due to a physical or mental illness.
Description of new evidence: _____

☐ My loss was the direct result of a traumatic event.
Description of new evidence: _____

☐ My traumatic injury was not willfully caused by my own actions.
Description of new evidence: _____

☐ I was not committing or attempting to commit a felony when my traumatic injury occurred.
Description of new evidence: _____

☐ I did not willfully use an illegal or controlled substance leading up to my traumatic injury.
Description of new evidence: _____

☐ My loss was not the result of a medical or surgical procedure.
Description of new evidence: _____

☐ My loss was not the result of an attempted suicide.
Description of new evidence: _____

☐ Other (reason is not listed above).
Description of new evidence: _____

8. Please provide any additional supporting details to be considered when your appeal is reviewed.

X

Signature

Date Signed (MM DD YYYY)

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

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 Alliance Account
An interest-bearing account will be established in the name of the Servicemember, who can access the money using the draft book. A guardian or power of attorney may sign Alliance Account® drafts on behalf of the Servicemember, if proof of appointment is submitted with the claim.

Payment Option 2 – Electronic Funds Transfer
This option can be selected by the Servicemember or, if applicable, the guardian, power of attorney, or military trustee. Payment will be made to the Servicemember's bank account, or in the case of a military trustee, the trusteeship account.

Payment Option 3 – Check
A check will be issued to the Servicemember, guardian, power of attorney, or military trustee on behalf of the Servicemember.

Please choose one of the three payment options below:

☐ **Payment Option 1—Prudential's Alliance Account®**
Complete the mailing address below (street address only, no PO boxes).

Servicemember's Mailing Address for Payment—No PO Boxes

Apartment, Ward or Room (if any)

City

State

ZIP Code

☐ **Payment Option 2—Electronic Funds Transfer (EFT)**
To have the payment made by EFT, fill in your banking information below.

Bank Routing Number

Bank Account Number

☐ Checking ☐ Savings

Bank Name

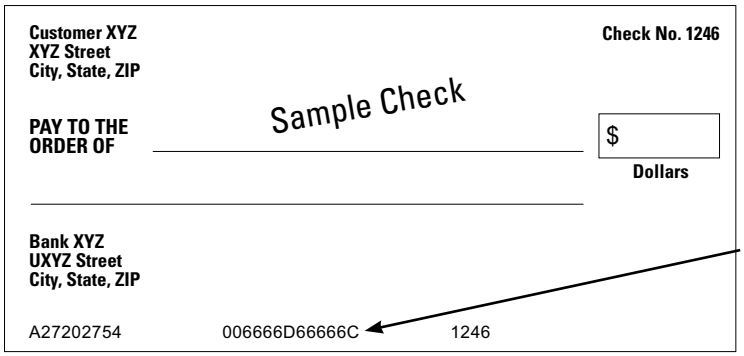
Bank Phone Number

First Name

MI

Last Name

The **bank routing number** is always 9 digits and appears between the ⑆ symbols



Bank Routing Number | Bank Account Number | Check Number (not needed)

The **bank account number** varies in length and may contain dashes or spaces. The ⑈ symbol indicates the end of the account number.

☐ **Payment Option 3—Check**
Important: If you are a guardian, power of attorney, or military trustee you must complete the information below when requesting a check.

Mailing Address for Payment—No PO Boxes

Apartment (if any)

City

State

ZIP Code

Financial Counseling

VA sponsors financial counseling for TSGLI recipients.

To receive this counseling, check the box below.

☐ **I would like to receive financial counseling with my TSGLI benefit. This counseling is offered at no cost to you.**

You should get financial counseling as soon as possible after receiving your insurance money and before making any major financial decisions. For more information on this benefit, visit **http://www.benefits.va.gov/insurance/bfcs.asp**.

Signature

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

X

Signature of servicemember guardian, power of attorney, or military trustee

Date Signed (MM DD YYYY)

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

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

The Servicemember, 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:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

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:

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

X

Signature of Servicemember guardian, power of attorney, or military trustee

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

Date Signed (MM DD YYYY)

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 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 10 hours 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.