



## SUPPLEMENTAL DESIGNATION OF BENEFICIARY - GOVERNMENT LIFE INSURANCE

**NOTE:** Before completing the form, please note we highly recommend updating your beneficiary designation directly online at <https://www.insurance.va.gov/home>. It is safe, secure and instant. 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.

VETERAN'S SOCIAL SECURITY NUMBER

-                      -

**IMPORTANT** - The beneficiaries listed below are in addition to those listed on my completed VA Form 29-336, *Designation of Beneficiary - Government Life Insurance* that was signed on \_\_\_\_\_ (Date Signed).

### SECTION I - BENEFICIARY DESIGNATION INFORMATION - PRINCIPAL

**IMPORTANT** - The total for all principal beneficiaries **must** equal **100%**. If the designated fractions do not add up to 100%, equal shares will be paid.

#### 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

-

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) ▶**

**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 BENEFICIARY 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 - CONTINGENT**

**FIRST CONTINGENT BENEFICIARY IDENTIFYING INFORMATION**

**IMPORTANT** - The total for all contingent beneficiaries **must** equal **100%**. If the designated fractions do not add up to 100%, equal shares will be paid.

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) ►**

**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

—                  —

**SECOND CONTINGENT BENEFICIARY IDENTIFYING INFORMATION (Continued)**

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

—

CONTINGENT BENEFICIARY EMAIL ADDRESS

CONTINGENT BENEFICIARY 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 (Continued)**

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 - ADDITIONAL INSTRUCTIONS**

**NOTE:** YOUR INSURANCE PROCEEDS WILL BE AUTOMATICALLY PAID ACCORDING TO THE AUTOMATIC SURVIVORSHIP CLAUSE DETAILED IN SECTION V BELOW. IF YOU DO NOT WANT YOUR INSURANCE PAID THIS WAY, PLEASE EXPLAIN BELOW HOW YOU WANT IT PAID.

## SECTION IV - CERTIFICATION AND SIGNATURE

**I Certify that** I am the policyholder and I understand that:

1. Unless otherwise noted in Section III, 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 based on the following order.
    - (1) My surviving spouse.
    - (2) My children and decedents of deceased children.
    - (3) My parents or their surviving children.
    - (4) The duly appointed executor or administrator of my estate.
    - (5) My other next of kin under laws of my domicile at time of my death.
2. This change cancels all prior beneficiary and option selections and applies to all Government Life Insurance policies.
3. For all programs other than VALife, by law, if a designated principal beneficiary does not file a claim for payment within one year 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 two years of the date of my death, my insurance will be paid in accordance with 38 U.S.C. 1917 (f) or 38 U.S.C. 1952(c). If I do not designate a beneficiary, my insurance will be paid according to the order of precedence listed in Item 1 of this section.
4. For VALife, by law, if the designated beneficiary does not file a claim for the payment within one year of the date of my death, or if payment to the designated beneficiary within that period is prohibited by Federal statute or regulation, my insurance will be paid based on the order of precedence listed in Item 1 of this section. Beneficiaries listed under the order of precedence may file a claim for such payment during the one year period following the period as if the designated beneficiary had predeceased the veteran.
5. Federal regulations pertaining to designating beneficiaries of Government life insurance require that the designation be valid. If any part of the designation in either the principal or contingent beneficiary section is unclear, ambiguous, or not legally acceptable, then the previous beneficiary designation will remain effective, or the insurance will be paid based on the order of precedence listed in Item 1 of this section.

**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 ( <i>Sign in ink</i> )	DATE SIGNED (MM/DD/YYYY)  -                      -
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**NOTE:** An "X" for a signature is acceptable when it is witnessed by two people not named on the designation.

PRINT NAME OF <b>FIRST</b> WITNESS (First-Middle Initial-Last)		PRINT NAME OF <b>SECOND</b> WITNESS (First-Middle Initial-Last)	
MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)		MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)	
TELEPHONE NUMBER (Include Area Code)		TELEPHONE NUMBER (Include Area Code)	
SIGNATURE OF <b>FIRST</b> WITNESS (Sign in ink)	DATE SIGNED (MM/DD/YYYY)	SIGNATURE OF <b>SECOND</b> WITNESS (Sign in ink)	DATE SIGNED (MM/DD/YYYY)

<b>THIS COMPLETED FORM MAY BE SUBMITTED BY:</b>	
<b>MAIL</b>	<b>ONLINE</b>
VARO & IC (B&O) P. O. Box 8638 Philadelphia, PA 19101	Upload the form using our secure website at <a href="http://www.insurance.va.gov">www.insurance.va.gov</a>

**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](http://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.