OMB Control No. 2900-0149
Respondent Burden: 15 minutes
Expiration Date: XX/XX/20XX

APPLICATION FOR CONVERSION GOVERNMENT LIFE INSURANCE

PRIVACY ACT INFORMATION: No insurance may be converted unless a completed application form has been received (38 U.S.C. 1904 and 1942). The 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 5, Code of Federal Regulations 1.526 for routine uses as identified in 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 required to obtain or retain benefits. The responses you submit are considered confidential (38 USC 5701).

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control Number. The OMB control number for this project is 2900-0149, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 15 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at VACOPaperworkReduAct@VA.gov. Please refer to OMB Control No. 2900-0149 in any correspondence. Do not send your completed VA Form 29-0152 to this email address.

IMPORTANT
(Answer all items. (See VA Pamphlet 29-73-1)
Do not return policy with this form.)

1. INSURANCE POLICY NUMBER TO BE CONVERTED *(Include letter prefix) (If more than one policy, please complete a separate form for each policy number)*

2. FIRST, MIDDLE, LAST NAME OF INSURED AND MAILING ADDRESS FOR INSURANCE PURPOSES *(Include number and street or rural route, P.O. Box, city, state, ZIP Code and country)*

3. VA CLAIM NUMBER *(If any)*

4. SOCIAL SECURITY NUMBER

5. DAYTIME TELEPHONE NUMBER *(Include Area Code)*

6A. PERMANENT PLAN(S) APPLIED FOR

☐ ORDINARY LIFE ☐ ENDOWMENT AT AGE 60
☐ 20 PAYMENT LIFE ☐ ENDOWMENT AT AGE 65
☐ 30 PAYMENT LIFE ☐ MODIFIED LIFE 65
☐ 20 YEAR ENDOWMENT ☐ MODIFIED LIFE 70

6B. AMOUNT OF INSURANCE TO BE CONVERTED

$

6C. IF YOU ARE NOT CONVERTING THE ENTIRE POLICY, DO YOU WISH TO CONTINUE ANY TERM INSURANCE?

☐ YES ☐ NO *(If "YES" enter amount $ ____________)*

7. METHOD OF PREMIUM PAYMENT

A. DESIRED METHOD OF PAYMENT *(Check one)*

☐ DIRECT PAYMENT TO VA *(If checked, complete Item 7B)*
☐ MONTHLY DEDUCTION FROM VA PENSION OR COMPENSATION
☐ MONTHLY ALLOTMENT FROM RETIREMENT/ACTIVE SERVICE PAY
☐ VA MATIC *(Automatic Checking Account deduction)*

B. DESIRED METHOD FOR DIRECT PAYMENT OF FUTURE PREMIUMS *(Check one)*

☐ MONTHLY ☐ ANNUAL

8. PAYMENT AMOUNT

AMOUNT OF FIRST PREMIUM ▶	$

9A. ARE YOU NOW DISABLED?

☐ YES ☐ NO *(If "YES," give name of disability below and complete Items 9B and 9C) (If "No," go to Item 10)*

9B. DATE LAST TREATED BY PHYSICAN OR HOSPITAL *(Include VA Physician or hospital)*

9C. DOES YOUR DISABILITY PREVENT YOU FROM WORKING?

☐ YES ☐ NO *(If "YES," explain fully below)*

UPLOAD:
The fastest and most secure way to send your application to VA Insurance is to use the document upload service at https://insurance.va.gov/home/IDU.

OR MAIL THE COMPLETED FORM TO:
VAROIC
P.O. BOX 42954
PHILADELPHIA, PA 19101

10A. SIGNATURE OF APPLICANT

10B. DATE OF APPLICATION

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE, CALL US TOLL-FREE AT 1-800-669-8477.