



Department of Veterans Affairs

APPLICATION FOR ORDINARY LIFE INSURANCE
REPLACEMENT INSURANCE FOR MODIFIED LIFE REDUCED
AT AGE 65
NATIONAL SERVICE LIFE INSURANCE

1. INSURANCE FILE NUMBER *(Include letter prefix)*

2. EMAIL ADDRESS

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 5, Code of Federal Regulations 1.526 for routine uses identified in VA system of records, 36VA29, Veterans and Uniformed Services Personnel Programs of U.S. Government Life Insurance - VA, and 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 2900-0166, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 5 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 YACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0166 in any correspondence. Do not send your completed VA Form 29-8485 to this email address.

IMPORTANT - This application and the initial premium must be submitted to the Department of Veterans Affairs before your 65th birthday.


3. FIRST NAME - MIDDLE NAME - LAST NAME OF INSURED

4A. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or P.O., State and ZIP Code)*

4B. IS THIS A CHANGE OF ADDRESS FOR YOUR INSURANCE RECORDS? *(Check one)*

YES NO

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

I wish to apply for the amount of insurance shown in Item 6, the block to the right, as replacement for the insurance that will end on the day before my 65th birthday. 

6. AMOUNT OF INSURANCE APPLIED FOR

I understand that the beneficiary designation and optional settlement under this new policy will remain the same as that on my Modified Life policy and will remain so until I submit a change in writing to the Department of Veterans Affairs.

7. SIGNATURE OF INSURED *(Do not print) (Sign in ink)*

8. DATE OF APPLICATION *(MM/DD/YYYY)*

9. PLEASE SUBMIT THIS APPLICATION WITH YOUR FIRST PREMIUM PAYMENT TO VA USING THE OPTIONS BELOW.

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

MAIL THE COMPLETED FORM TO:
VAROIC
P.O. BOX 7787
PHILADELPHIA, PA 19101

You may submit payments to VA Life Insurance through your preferred banking institution online Bill Pay feature. Select "**VA Life Insurance**" as the Payee and enter your Insurance File Number as the Account Number.

VA Collections Address:
PO Box 4019
Portland, OR 97208-4019