Claim for Accelerated Benefits

Servicemembers' Group Life Insurance
Family Coverage (FSGLI)

The Accelerated Benefit Option allows the service member to receive up to 50% of his/her spouse's FSGLI benefit if the spouse has been diagnosed by a physician as being terminally ill with nine (9) months or less to live (See 38 U.S.C. 1980). The service member, their spouse, or an alternate applicant acting on each of their behalf can apply for this benefit. The alternate applicant can only apply on behalf of the service member and/or their spouse if all of the following criteria are met:

- service member's and/or service member's spouse's physician certifies they are medically incapacitated*;
- the alternate applicant has power of attorney, guardianship, or conservatorship of the service member or their spouse, or is the Defense Finance Accounting Service-appointed military trustee (for service members only).

*Medically incapacitated is defined as: an individual who has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

The amount of insurance proceeds payable to the service member at the time of his/her spouse's death will be reduced by the amount of accelerated benefit the service member chooses to receive now. The FSGLI premium will be lowered to reflect the reduced coverage amount.

How to Submit a Claim for Accelerated Benefits

The service member or alternate applicant, the service member's spouse or their alternate applicant, the service member's spouse's physician, and the service member's branch of service must complete the attached forms as indicated. Completed forms should be submitted as follows:

Active duty service members/Reservists	**Army National Guard**
1. The service member should complete the top of page 3. If the service member is medically incapacitated, the alternate applicant should complete the top of page 3 on behalf of the service member and attach one of the following documents indicating their authority to act on the service member's behalf: • guardianship/conservatorship papers • power of attorney • Proof of military trusteeship appointment (DoD Form 2827 - "Application for Trusteeship") 2. The service member's spouse should complete the authorization to release medical records on the bottom of page 3. If the service member's spouse is medically incapacitated, the alternate applicant for the spouse should complete the bottom of page 3 on behalf of the service member's spouse and attach one of the following documents indicating their authority to act on the service member's spouse's behalf: • guardianship/conservatorship papers • power of attorney 3. The service member's spouse's physician should complete page 4. 4. Submit the entire form to the service member's personnel office to complete the top of page 5. 5. After completing the top of page 5, the personnel office should submit the entire form to the service member's casualty office to complete the bottom portion of page 5.	1. The service member should complete the top of page 3. If the service member is medically incapacitated, the alternate applicant should complete the top of page 2 on behalf of the service member and attach one of the following documents indicating their authority to act on the service member's behalf: • guardianship/conservatorship papers • power of attorney • Proof of military trusteeship appointment (DoD Form 2827 - "Application for Trusteeship") 2. The service member's spouse should complete the authorization to release medical records on the bottom of page 3. If the service member's spouse is medically incapacitated, the alternate applicant for the spouse should complete the bottom of page 3 on behalf of the service member's spouse and attach one of the following documents indicating their authority to act on the service member's spouse's behalf: • guardianship/conservatorship papers • power of attorney 3. The service member's spouse's physician should complete page 4. 4. Submit the entire form to the service member's state National Guard headquarters to complete page 5.

Important Information

- If the claim for accelerated benefits is approved, the service member will receive a payment for the amount requested.
- Once the payment is cashed or deposited, the accelerated benefit cannot be revoked.
- The service member can receive this benefit only once during the spouse's lifetime.
- The service member may use this benefit for any purpose.
- If the spouse is covered under SGLI Family Coverage, the Office of Servicemembers' Group Life Insurance (OSGLI) will notify the service member's branch of service to reduce the face amount of the spouse's coverage and premium rate.
- If the claim is not approved, the service member has the option of submitting additional medical information or reapplying at a later date.

The Office of Servicemembers' Group Life Insurance (OSGLI) administers Servicemembers' Group Life Insurance and Veterans' Group Life Insurance under the supervision of the Department of Veterans Affairs. OSGLI is a division of The Prudential Insurance Company of America.

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 2900-0618, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 12 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. 2900-0618 in any correspondence. Do not send your completed VA Form SGLV 8284A to this email address.

Method of Payment

I HEREBY CERTIFY that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld. My preferred method of payment is:

☐ Lump Sum – Check (Checks will be issued in the name of the insured even if an alternate applicant applied on behalf of the insured.)

☐ Lump Sum – Electronic Funds Transfer (EFT) – Please provide your banking information below. (This payment option is not available if claim is being made by an alternate applicant other than the insured.)

For EFT only – Please provide your banking information below to have the benefit paid by Electronic Funds Transfer.

Bank Routing Number

Bank Account Number

☐ Checking
☐ Savings

Bank Name

Bank Phone Number

First Name

MI

Last Name

Customer's Name
Street Address
City, State, Zip

Check No. 1234

Sample Check

PAY TO THE
ORDER OF______ $ Dollars

Bank Name
Street Address
City, State, Zip

⑆ 223207349 ⑆ 00123012201234⑈ 1234

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

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

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

If I have selected payment by Electronic Funds Transfer, I authorize The Prudential Insurance Company of America (Prudential) to make electronic deposits on my Death Claim proceeds into the above account. I understand that I must be the named account holder on this account and that any deposit made to an inactive account agreement will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such Death Claim proceeds is credited to this account in error, I authorize Prudential to withdraw the difference between the benefit amount paid and the recalculated amount of the benefit actually due under the terms of the insurance coverage.

TO BE COMPLETED BY SERVICE MEMBER OR ALTERNATE APPLICANT.

CLAIM FOR ACCELERATED BENEFITS

Service member's name (first middle last)		**Service member's Social Security Number**
Service member's mailing address	**Service member's Branch of Service**	**Service member's duty status** ☐ **Active Duty** ☐ **Ready Reserves** ☐ **Army/Air National Guard** ☐ **Separated/Discharged** (120-day free coverage period) (provide separation/discharge date)
Service member's telephone number		
Spouse's name (first middle last)	**Spouse's Social Security Number**	
Amount of spouse's coverage $	**Amount of Claim** (Cannot exceed 50% of spouse's total coverage) $	

I acknowledge that I (or the alternate applicant) have read all of the attached information about the accelerated benefit. I understand that I can get this benefit only once during my spouse's lifetime and that I can use it for any purpose I choose. I further understand that the face amount of my spouse's coverage will be reduced by the amount of accelerated benefit I choose to receive now.

Signature (service member or alternate applicant)________________________ **Date** ____________________

TO BE COMPLETED BY SERVICE MEMBER'S SPOUSE OR ALTERNATE APPLICANT

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To all physicians, hospitals, medical service providers, pharmacists, employers, other insurance companies, and all other agencies and organizations:

You are authorized to release a copy of all my medical records, including examinations, treatments, history, and prescriptions, to the Office of Servicemembers' Group Life Insurance (OSGLI) or its representatives.

Spouse's printed name ____

Spouse's signature (Spouse or spouse's alternate applicant signature) ________________ Date ____________________

A photocopy of this authorization will be considered as effective and valid as the original. Valid for one year from date signed.

TO BE COMPLETED BY SERVICE MEMBER'S SPOUSE'S PHYSICIAN

ATTENDING PHYSICIAN'S CERTIFICATION

Patient's name		**Patient's Social Security Number**
Diagnosis	**ICD-9-CM/ICD-10-CM Disease Code***	
Description of Present Medical Condition (Please attach results of x-rays, E.K.G. or other tests)		

Is the patient medically incapacitated?** ☐ Yes ☐ No

***Medically incapacitated is defined as: an individual who has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.*

The patient applied for an accelerated benefit under his/her government life insurance coverage. To qualify, the patient must have a life expectancy of nine (9) months or less. Does your patient meet this requirement? ☐ Yes ☐ No

Attending physician's name (please print)	**State in which you are licensed to practice**	**Specialty**
Mailing address	**Telephone number**	**Fax number**

Signature_______________________________________ **Date** ____________________

**International Classification of Diseases, 9th revision, Clinical Modification/International Classification of Diseases, 10th revision, Clinical Modification*

TO BE COMPLETED BY THE PERSONNEL OFFICE OF THE SERVICE MEMBER'S UNIT

BRANCH OF SERVICE STATEMENT

Service member's name	Service member's Social Security Number	Service member's Branch of Service
Spouse's Name	**Spouse's Social Security Number**	
Amount of FSGLI Coverage **$**	**Monthly premium amount** **$**	
Name and title of person completing this form	**Telephone number**	**Fax number**
Service member's duty station and address		

Signature of person completing this form

Date

Note: After completing this section, the personnel officer should submit the form to the service member's casualty branch.

TO BE COMPLETED BY THE SERVICE MEMBER'S CASUALTY BRANCH

Certified by:

Name

Title

Branch of Service	Certification date
Telephone number	**Fax number**

Notice: It is fraudulent to complete these forms with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.