



# CLAIM FOR ONE SUM PAYMENT GOVERNMENT LIFE INSURANCE

**NOTE:** This form should be used to submit all Veterans' Life Insurance claims except for Servicemember's Group Life Insurance (SGLI), Family Servicemember's Group Life Insurance (FSGLI) and Veteran's Group Life Insurance (VGLI).

## INSTRUCTIONS

**SUPPORTING DOCUMENTS:** SUBMIT A PHOTOCOPY OF THE VETERAN'S DEATH CERTIFICATE OR A STATEMENT FROM THE ATTENDING PHYSICIAN SHOWING DATE AND CAUSE OF DEATH. ONLY ONE DEATH CERTIFICATE OR STATEMENT FROM THE ATTENDING PHYSICIAN IS REQUIRED FOR OUR RECORDS. IF APPLICABLE, PLEASE PROVIDE A COPY OF THE DEATH CERTIFICATES FOR ANY DECEASED BENEFICIARIES.

### INSTRUCTIONS:

- If you are listed as a beneficiary to receive a lump sum payment for more than one policy for a veteran, then this claim form will be used for those policies as well.
- If the beneficiary is a minor or incompetent, the person having custody of the beneficiary should complete the form and provide her or her address. VA cannot issue payment directly to a minor beneficiary. Payment must be made to a court-appointed guardian or VA fiduciary. If a court-appointed guardian is already in place, please submit the court documents. Otherwise VA will request appointment of a VA fiduciary before payment can be issued.
- If you are completing and signing as the court-appointed guardian or attorney-in-fact (power of attorney) for an adult beneficiary, please include a copy of the court appointment or power of attorney. If neither of these are in place, VA will request appointment of a VA fiduciary before payment can be issued.
- Complete Part I, VI, and VII in full regardless of the type of beneficiary, and
- Complete Part II for Individual beneficiaries; otherwise, complete Part III for Trusts, Part IV for Estates, or Part V for Organizations, Charities or other Legal Entities.

### SECTION I: DECEASED VETERAN'S INFORMATION

(All information requested in this section is required)

1. FIRST, MIDDLE, LAST NAME OF INSURED VETERAN

2. SOCIAL SECURITY NUMBER

3. INSURANCE POLICY NUMBER

4. DATE OF DEATH (MM/DD/YYYY)

### SECTION II: BENEFICIARY'S INFORMATION

(If individual is the beneficiary, complete this section, then skip to Section VI)

5. FIRST, MIDDLE, LAST NAME OF BENEFICIARY

6. SOCIAL SECURITY NUMBER OF BENEFICIARY

7. DATE OF BIRTH OF BENEFICIARY

8. RELATIONSHIP TO INSURED

9. MAILING ADDRESS (Number and Street or P.O Box) (MUST BE COMPLETED)

10. MAILING ADDRESS (City, State, ZIP Code) (MUST BE COMPLETED)

11. EMAIL ADDRESS

12. DAYTIME TELEPHONE NUMBER (Include Area Code)

**IF YOU HAVE ANY QUESTIONS REGARDING YOUR GOVERNMENT LIFE INSURANCE,  
PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477.**

**SECTION III: TRUST INFORMATION**

(If a trust is the beneficiary, complete this section, then skip to Section VI)

**NOTE:** A copy of the trust agreement must be submitted with this form along with a voided check or copy of bank statement for the trust. For Testamentary Trusts **ONLY**, provide a copy of the Will and court appointment documents (i.e., Letters Testamentary, Letters of Administration).

13. FULL NAME OF TRUST

14. FULL NAME OF TRUSTEE

15. MAILING ADDRESS (Number and Street or P.O. Box, City, State, ZIP Code) (MUST BE COMPLETED)

16. DAYTIME TELEPHONE NUMBER (Include Area Code)

17. EMAIL ADDRESS

18. TRUST AGREEMENT DATE (MM/DD/YYYY)

19. EIN OR TIN NUMBER (FOR TRUST)

**SECTION IV: ESTATE INFORMATION**

(If a probated estate is the beneficiary, complete this section, then skip to Section VI)

**NOTE:** Please include a copy of the appointment papers issued by the court (i.e., Letters Testamentary, Letters of Administration).**NOTE:** If the estate is **not** probated, complete VA Form 29-541, *Certificate Showing Residence and Heirs of Deceased Veteran or Beneficiary* in lieu of this form so VA can determine payment eligibility. VA will notify each entitled heir to complete a VA Form 29-4125 once the heirs have been determined under the law.

20. FULL NAME OF ESTATE

21. FULL NAME OF COURT-APPOINTED EXECUTOR/ADMINISTRATOR

22. MAILING ADDRESS (Number and Street or P.O. Box, City, State, ZIP Code) (MUST BE COMPLETED)

23. DAYTIME TELEPHONE NUMBER (Include Area Code)

24. EMAIL ADDRESS

25. EIN OR TIN NUMBER (FOR ESTATE)

**SECTION V: ORGANIZATION/OTHER LEGAL ENTITY INFORMATION**

(If an organization, charity, or other legal entity is the beneficiary, complete this section, then skip to Section VI)

**NOTE:** Please include letters of resolution/authority authorizing the representative to act/sign on behalf of the organization.

26. FULL NAME OF ORGANIZATION, CHARITY, OR LEGAL ENTITY

27. FULL NAME OF AUTHORIZED REPRESENTATIVE

28. MAILING ADDRESS (Number and Street or P.O. Box, City, State, ZIP Code) (MUST BE COMPLETED)

29. DAYTIME TELEPHONE NUMBER (Include Area Code)

30. EMAIL ADDRESS

31. EIN OR TIN NUMBER (FOR ORGANIZATION, CHARITY, OR LEGAL ENTITY)

**SECTION VI: FINANCIAL INFORMATION**  
(All information requested in this section is required)

THE DEPARTMENT OF TREASURY HAS MANDATED THAT FEDERAL PAYMENTS BE ISSUED VIA ELECTRONIC FUNDS TRANSFER (EFT). COMPLETE THE BANK ACCOUNT INFORMATION BELOW TO RECEIVE THIS PAYMENT ELECTRONICALLY. THE ACCOUNT MUST BE IN THE NAME OF THE PERSON, TRUST, ESTATE, ORGANIZATION/CHARITY/LEGAL ENTITY OF THE DESIGNATED BENEFICIARY.

**DIRECT DEPOSIT/ELECTRONIC FUNDS TRANSFER INFORMATION: Please provide your banking information below.**

32. NAME OF FINANCIAL INSTITUTION	33. TYPE OF ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
34. BANK ROUTING NUMBER (NINE DIGIT FIELD)	35. BANK ACCOUNT NUMBER

The **bank routing number** is always 9 digits and appears between the |: symbols.

Beneficiary Name Street Address City, State, ZIP	<b>SAMPLE CHECK</b>	Check No. 1234
PAY TO THE ORDER OF _____	\$ _____	
_____ Dollars		
:123456789 :    1617284958569678  :    1234		

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

Bank Routing Number                      Bank Account Number                      Check Number (Not needed)

**NOTE: DO NOT USE A DEPOSIT SLIP TO LOCATE YOUR BANKING INFORMATION. THIS INFORMATION CAN BE DIFFERENT THAN YOUR ACCOUNT INFORMATION AND COULD RESULT IN DELAYING PAYMENT.**

**SECTION VII: SIGNATURE AND CERTIFICATION**  
(All information requested in this section is required)

**IMPORTANT:** This form must be signed by the beneficiary, guardian, attorney-in-fact, or fiduciary, in Item 36, for payment to be made for an individual beneficiary. Otherwise, the trustee (for trusts), executor/administrator (for estates), or authorized representative (for an organization, charity, or legal entity) must sign in Item 36, for payment to be made.

**CERTIFICATION:** I certify that the above entries are true and correct to the best of my knowledge and belief.

36. SIGNATURE OF BENEFICIARY (Guardian, Attorney-In-Fact, or Fiduciary), OR TRUSTEE, EXECUTOR, OR REPRESENTATIVE	37. DATE SIGNED (MM/DD/YYYY)
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**NOTE:** An "X" for signature is acceptable if the beneficiary cannot sign his/her name but is competent to handle his/her own affairs, and "X" for a signature is acceptable when witnessed by two impartial people. Impartial person is one not having a vested interest.

38A. PRINTED NAME OF FIRST WITNESS	38B. MAILING ADDRESS OF FIRST WITNESS	
38C. TELEPHONE NUMBER OF FIRST WITNESS (Include Area Code)	38D. SIGNATURE OF FIRST WITNESS	38E. DATE SIGNED (MM/DD/YYYY)
39A. PRINTED NAME OF SECOND WITNESS	39B. MAILING ADDRESS OF SECOND WITNESS	
39C. TELEPHONE NUMBER OF SECOND WITNESS (Include Area Code)	39D. SIGNATURE OF SECOND WITNESS	39E. DATE SIGNED (MM/DD/YYYY)

**YOU CAN SUBMIT THE COMPLETED FORM BY DOCUMENT UPLOAD OR MAILING TO THE ADDRESS BELOW.**

<b>DOCUMENT UPLOAD:</b> Upload the form using our secure website at: <a href="https://insurance.va.gov/home/ID">https://insurance.va.gov/home/ID</a>	<b>MAIL TO:</b> VA Insurance Center, P.O. Box 7208, Philadelphia, PA 19101
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**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 identified in the VA system of records, 36VA29, Veterans and Uniformed Services Personnel Programs of U.S. Government Life Insurance Records-VA, and published in the Federal Register. Your obligation to respond is voluntary, but your failure to provide us the information could impede processing. 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.

**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 2900-0060, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 6 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](mailto:VACOPaperworkReduAct@VA.gov). Please refer to OMB Control No. 2900-0060 in any correspondence. Do not send your completed VA Form 29-4125 to this email address.