OMB Control No. 2900-0020
Respondent Burden: 10 minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

SUPPLEMENTAL DESIGNATION OF BENEFICIARY - GOVERNMENT LIFE INSURANCE

NOTE: If you set up an online account at https://insurance.va.gov/home/, you can update your beneficiary designation directly online safely and instantly. You may also download the form and complete manually. If completed manually, print the information requested in ink, neatly, and legibly to expedite processing of the form. You can also submit through our safe and secure document upload service at https://insurance.va.gov/Home/IDU or via mail at VARO & IC (B&O), P.O BOX 8638, PHILADELPHIA, PA 19101.

FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN/INSURED:

PRINCIPAL BENEFICIARY SOCIAL SECURITY NUMBER ___ – ___ – ____

8. LIST ALL POLICY NUMBERS

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).*

INSTRUCTIONS FOR COMPLETING THIS FORM

Use this form to designate additonalo beneficiaries in addition to those listed on your completed VA Form 29-336.

- Use this form to designate or make changes to the beneficiary(ies) of your Government Life Insurance death proceeds. **This form does not apply for use in Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI) beneficiary designations.**
- The information on this form will replace any prior beneficiary designations.
- You may name any person, firm, corporation/organization, trust, or your estate as your beneficiary. You have the right to change your beneficiary at any time without the knowledge or consent of the prior beneficiary. A state court or divorce decree cannot restrict this right and is not binding on you. You may change your beneficiary at any time by completing a new Government Life Insurance Beneficiary Designation form.
- This form ***cannot*** be used to reinstate your coverage if your insurance is not in force due to failure to pay timely premiums.
- 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, if no prior designations exist or are invalid, the insurance will be paid based on the order of precedence.
- **Any alterations, erasures, and cross-outs on this form will invalidate this designation.**
- **All pages must be returned at the same time with a signature on the final page to be valid.**
- **If you do not name a specific beneficiary or if all your designated beneficiaries pre-decease you, your insurance will be paid by order of precedence:**
  1) Surviving spouse,
  2) Children and decedents of deceased children,
  3) Parents or their surviving children (Veteran's Siblings),
  4) The duly appointed executor or administrator of my estate,
  5) Other next of kin based upon the laws of the Veteran's residence (domicile) at time of death.

  THIS DESIGNATION WILL APPLY TO ALL POLICIES

SECTION I - BENEFICIARY DESIGNATION INFORMATION - PRINCIPAL

Principal Beneficiaries are the person(s) or entity(ies) you choose to receive your life insurance proceeds. If a designated principal beneficiary predeceases you, the proceeds will be paid to the remaining principal beneficiaries in equal shares or all to the sole remaining principal beneficiary. If no principal beneficiaries remain, we would pay the contingent beneficiaries, or, if none, we would pay by order of precedence. We will pay via lump sum. If interested in other payment options, please call our toll-free number 1-800-669-8477.
IMPORTANT - The total for all principal beneficiaries **must** equal **100%**. If the designated shares do not add up to 100%, equal shares will be paid.

PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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 IDENTIFYING INFORMATION *(Continued)*

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

Note: Please use percentages when identifying specific shares. **SHARES:** %

PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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

Note: Please use percentages when identifying specific shares. **SHARES:** %

PRINCIPAL BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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 IDENTIFYING INFORMATION *(Continued)*

PRINCIPAL BENEFICIARY EMAIL ADDRESS

PRINCIPAL BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

Note: Please use percentages when identifying specific shares. **SHARES:** ☐☐☐ **%**

Do not name additional principal beneficiaries in Section II of this form. Please use another VA Form 29-336a, *Supplemental Designation of Beneficiary* to add additional principal beneficiaries or attach a signed sheet of paper with your beneficiaries. Make sure you also include your name, date, and policy number.

SECTION II - BENEFICIARY DESIGNATION INFORMATION - CONTINGENT

Contingent Beneficiaries are the person(s) or entity(ies) you choose to receive your life insurance proceeds if the principal beneficiary (ies) die before you, or, if an organization is named principal beneficiary, it dissolves before you die. In the event that a designated contingent beneficiary predeceases you, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary. If none, then we would pay by order of precedence. We will pay via lump sum. If interested in other payment options, please call our toll-free number 1-800-669-8477. **IMPORTANT - The total for all principal beneficiaries must equal 100%. If the designated shares do not add up to 100%, equal shares will be paid.**

CONTINGENT BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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 –

CONTINGENT BENEFICIARY EMAIL ADDRESS

CONTINGENT BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

Note: Please use percentages when identifying specific shares. **SHARES:** ☐☐☐ **%**

CONTINGENT BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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 –

CONTINGENT BENEFICIARY IDENTIFYING INFORMATION *(Continued)*

CONTINGENT BENEFICIARY EMAIL ADDRESS

CONTINGENT BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

Note: Please use percentages when identifying specific shares. **SHARES:** ☐☐☐ **%**

CONTINGENT BENEFICIARY IDENTIFYING INFORMATION

TYPE OF BENEFICIARY (Check one)

☐ SPOUSE ☐ CHILD ☐ PARENT ☐ SIBLING ☐ OTHER ☐ ESTATE ☐ CHARITY/ORGANIZATION ☐ ESTATE

☐ TRUST **(For trusts ONLY, check this box and complete the share amount, then skip to Section III)**

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 –

CONTINGENT BENEFICIARY EMAIL ADDRESS

CONTINGENT BENEFICIARY DAYTIME TELEPHONE NUMBER *(Include Area Code)*

INSURANCE PAYMENT DISTRIBUTION

Note: Please use percentages when identifying specific shares. **SHARES:** ☐☐☐ **%**

Please use another VA Form 29-336a, *Supplemental Designation of Beneficiary* to add additional contingent beneficiaries or attach a signed sheet of paper with your beneficiaries clearly listed. Make sure you include your name, date, and policy number.

SECTION III- TRUST DESIGNATIONS

Complete this section if a Trust has been named as a principal or contingent beneficiary in Section II or III. Fill in the name and address for each trustee. Fill in the title and date of the Trust Agreement in the space provided. Any time the trust is amended with a new date, a new designation **MUST** be submitted to be valid. If there are amendments after the trust is designated or the trust is no longer funded, then we cannot pay the trust and will pay to other designated principal or contingent beneficiary (ies), or order of precedence.

Instructions:

- Select "Trust"in the type of beneficiary box in Section II (If designated as principal beneficiary) or III (If designated as contingent beneficiary)
- Indicate the percentage to be assigned to the trust in Section II or III under Insurance Payment Distribution
- Then, complete the section below:

Examples on how to designate various trusts:

- Inter Vivos Trust (A trust you set up during your Lifetime)
  i.e.: Name of Trust: *"John A Smith Trust Agreement"*, Date of Trust: *"September 18, 2023"*
- Testamentary Trust (A trust that is set up when you die, according to the terms in your will per probate laws)
  i.e.: *"Trust as provided in my Last Will and Testament"*
- Special Needs Trust: Trust created to provide assets to support an individual with disability or illness.
  i.e.: Name of Trust: *"The John Smith Special Needs Trust"*, Date of Trust: *"September 18, 2023"*

NAME OF TRUST

DATE OF TRUST (MM/DD/YYYY

☐☐ – ☐☐ – ☐☐☐☐

The following information is used to assist VA in obtaining a claim. It is **NOT** part of the designation.

1a. TRUSTEE NAME (FIRST, MI, LAST)

1b. TRUSTEE ADDRESS

1a. TRUSTEE NAME (FIRST, MI, LAST)

1b. TRUSTEE ADDRESS

SECTION III- TRUST DESIGNATIONS *(Continued)*

1c. TRUSTEE DAYTIME PHONE NUMBER	1c. TRUSTEE DAYTIME PHONE NUMBER
1d. TRUSTEE EMAIL ADDRESS	1d. TRUSTEE EMAIL ADDRESS

SECTION V - CERTIFICATION AND SIGNATURE

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

1. 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 (Veteran's Siblings),
   (4) The duly appointed executor or administrator of my estate,
   (5) Other next of kin based upon the laws of the Veteran's residence (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.** 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.** 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.

IMPORTANT - The Veteran/Insured must sign and date the form. A VA Fiduciary, Power of Attorney or Court-Appointed Guardian cannot designate beneficiaries for the Veteran/Insured. In such cases, a specific court order is required. Please contact our toll-free number at 1-800-669-8477 for more information on court order requirements.

SIGNATURE OF VETERAN/INSURED *(Sign in ink)*	DATE SIGNED (MM/DD/YYYY ☐☐ – ☐☐ – ☐☐☐☐

NOTE: The section below should only be completed if the Veteran/Insured is competent but cannot sign their name. In such cases, the Veteran/Insured must make an "X" in the signature block and two impartial witnesses to the signature must sign below. An impartial witness cannot be someone named as a beneficiary on this form.

PRINT NAME OF **FIRST** WITNESS (First-Middle Initial-Last)		PRINT NAME OF **SECOND** 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 **FIRST** WITNESS (Sign in ink)	DATE SIGNED (MM/DD/YYYY)	SIGNATURE OF **SECOND** WITNESS (Sign in ink)	DATE SIGNED (MM/DD/YYYY)

THIS COMPLETED FORM MAY BE SUBMITTED BY:

Online Policy Access (OPA)	DOCUMENT UPLOAD	MAIL
Using your online account, update your designation securely at: https://www.insurance.va.gov/home	**Upload the form using our secure website at https://insurance.va.gov/home/IDU**	**VARO & IC (B&O) P.O. BOX 8636 PHILADELPHIA, PA 19101**

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: 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 2900-0020, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 10 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. 2900-0020 in any correspondence. Do not send your completed VA Form 29-336a to this email address.