OMB Approved No. 2900-0060
Respondent Burden: 6 Minutes
Expiration Date: 12/31/2027

VA | U.S. Department of Veterans Affairs

EZ – BENEFICIARY CLAIM FOR ONE SUM PAYMENT
GOVERNMENT LIFE INSURANCE

INSTRUCTIONS

This form is intended for individual beneficiaries of VA Life Insurance **Only**.

DO NOT submit this form for:

1. Claims for which the beneficiary is a Minor, Trust, Funeral Home, Estate, Charity/Organization, or has an Appointed Guardian, Fiduciary or Power of Attorney. These Claimants must use the standard 29-4125-ARE.
2. Servicemembers' Group Life Insurance (SGLI), Veterans' Group Life Insurance (VGLI), or Family Servicemembers' Group Life Insurance (FSGLI) claims. Use Claim Form SGLV 8283.

SUPPORTING DOCUMENTS REQUIRED: SUBMIT A PHOTOCOPY OF THE VETERAN'S DEATH CERTIFICATE (OR AMENDED) SHOWING CAUSE OF DEATH OR IF NOT AVAILABLE, A STATEMENT FROM THE ATTENDING PHYSICIAN SHOWING DATE AND CAUSE OF DEATH. IF APPLICABLE, PLEASE PROVIDE A COPY OF THE DEATH CERTIFICATES FOR ANY DECEASED BENEFICIARIES.

INFORMATION IN ALL SECTIONS IS REQUIRED.

SECTION I: DECEASED VETERAN'S INFORMATION

1. FIRST, MIDDLE, LAST NAME OF INSURED VETERAN		
2. SOCIAL SECURITY NUMBER	3. INSURANCE POLICY NUMBER(S), (IF KNOWN)	4. DATE OF DEATH *(MM/DD/YYYY)*

SECTION II: BENEFICIARY'S INFORMATION

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)*	10. CITY, STATE	11. ZIP CODE
12. EMAIL ADDRESS	13. DAYTIME TELEPHONE NUMBER *(Include Area Code)*	

SECTION III: DIRECT DEPOSIT/ELECTRONIC FUNDS TRANSFER INFORMATION

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 DESIGNATED BENEFICIARY.

14. NAME OF FINANCIAL INSTITUTION	15. TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS
16. BANK ROUTING NUMBER *(NINE DIGIT FIELD)*	17. BANK ACCOUNT NUMBER

SECTION IV: SIGNATURE AND CERTIFICATION

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

18. SIGNATURE OF BENEFICIARY	19. DATE SIGNED *(MM/DD/YYYY)*

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

DOCUMENT UPLOAD: Upload the form using our secure website at: https://insurance.va.gov/home/IDU or scan the QR code here:

MAIL TO:
Department of Veterans Affairs Insurance Center
PO Box 5209 Janesville, WI 53547-5209

PRIVACY ACT INFORMATION: 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 2900-0060, and it expires 12/31/2027. 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 **vapra@va.gov**. Please refer to OMB Control No. 2900-0060 in any correspondence. Do not send your completed VA Form 29-4125EZ to this email address.