

# Instructions

## Application for Reinstatement of Coverage

### Completing the Form

1. Keep or discard this instruction sheet. You do not need to return it to us.
2. On the form, *I*, *you*, and *your* refer to the insured.
3. Type or print all entries on the form, except for your handwritten signature. Initial any erasures, corrections, or changes to the form. If you require additional space, attach a supplemental sheet. The separate sheet must contain your name, control number, and the date, and must be attached to the form.
4. The Reinstatement Amount is the amount of money needed to reinstate the coverage. The Reinstatement Amount is equal to three (3) times the monthly premium, based on the insured's current age. If you do not know the monthly premium amount, contact OSGLI.
5. The Reinstatement Amount must be enclosed with this application. Payment can be in the form of a check or money order. Checks and money orders should be made payable to OSGLI. If our office cannot approve this application, we will refund the money to the insured in full.
6. The insured or the insured's Attorney-in-Fact may apply for reinstatement of this insurance. If application is made by the Attorney-in-Fact, a copy of the Power of Attorney documentation must be attached to this form.
7. This form must be signed by the insured (or the insured's Attorney-in-Fact). The Attorney-in-Fact should sign the form as POA for the insured. For example, if John Smith is the POA for George Smith, then John Smith should sign this form as in the example below:

*John Smith, POA for George Smith*

### Where to Send the Completed Form

Send your completed, signed, and dated form to:

Office of Servicemembers' Group Life Insurance  
PO Box 41618  
Philadelphia, PA 19176-9913

*IMPORTANT: Do not return the form to the Department of Veterans Affairs.*

### If You Have Any Questions

If you have questions, call our Customer Service Department at **(800) 419-1473** between 8:00 a.m. and 5:00 p.m. Eastern time, or e-mail us at [osgli.osgli@prudential.com](mailto:osgli.osgli@prudential.com) anytime. For your convenience, you may also fax us at (800) 236-6142 or (973) 548-5300.

# Application for Reinstatement of Coverage

## Veterans' Group Life Insurance

Control No.: \_\_\_\_\_ Coverage Amount: \_\_\_\_\_  
 Surname: \_\_\_\_\_ Reinstatement Amount: \_\_\_\_\_

- YES!** I would like to reinstate my Veterans Group Life Insurance coverage in its current amount. I have enclosed the "**Reinstatement Amount**" above.
- I would like to reinstate my coverage at this time. I would also like to reduce my coverage to \$\_\_\_\_\_. I understand that I can restore my coverage to its original amount within **five** years from the lapse date, but I must answer medical questions to do so. I have enclosed the "**Reinstatement Amount**" above.

**Please complete the following questionnaire. Your reply to each question must be truthful and complete.**

1. What is your current: Weight \_\_\_\_\_ Height \_\_\_\_\_
2. Have you ever been treated for or had any known indication of: YES NO
- |    |   |        |      |
|----|---|--------|------|
| a. | Heart disease?                                      | a.____ | ____ |
| b. | High Blood Pressure?                                | b.____ | ____ |
| c. | Lung or respiratory disorders?                      | c.____ | ____ |
| d. | Nervous disorder?                                   | d.____ | ____ |
| e. | Cancer or tumors?                                   | e.____ | ____ |
| f. | Disorder of the kidney, bladder, or urinary system? | f.____ | ____ |
| g. | Liver or gall bladder disorder?                     | g.____ | ____ |
| h. | Stomach or intestinal disorders?                    | h.____ | ____ |
| i. | Diabetes?   | i.____ | ____ |
3. Have you, within the past five years: YES NO
- |    |   |        |      |
|----|---|--------|------|
| a. | Been advised to have a surgical operation?  | a.____ | ____ |
| b. | Been a patient or advised to enter a hospital or health care facility?  | b.____ | ____ |
| c. | Consulted, been attended or examined by a doctor or other practitioner exclusive of annual or periodic physicals? | c.____ | ____ |
| d. | Used barbiturates, heroin, opiates, or other narcotics, or been treated for alcoholism?                           | d.____ | ____ |
4. Have you ever been diagnosed as having a disease or disorder of the immune system? 4.\_\_\_\_ \_\_\_\_
5. Have you ever been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS-related complex (ARC)? 5.\_\_\_\_ \_\_\_\_
6. Do you have any known physical impairments, deformities, or ill health not covered above? 6.\_\_\_\_ \_\_\_\_
7. Do you have a service-connected disability? 7.\_\_\_\_ \_\_\_\_  
 If yes, what is the VA File Number? \_\_\_\_\_

**Please provide complete details for all "yes" answers above. Use additional sheets of paper if necessary.**

Question Number	Nature of illness. Reason for any check-up, doctor's advice, treatment or medication prescribed.	Date illness began. Month/Year	Time lost from normal activities.	Full recovery Month/Year	(Print) Full doctor's and hospital name/ address

I declare that, to the best of my knowledge and belief, the above statements are complete and true. Any deception or false statement, either by reference, omission, or otherwise can result in loss of coverage or denial of a claim for benefits.

\_\_\_\_\_  
 Signature (Do not print) Date ( ) \$ \_\_\_\_\_  
Daytime phone number Amount submitted

# Application for Pay By Allotment

## Veterans' Group Life Insurance

### AUTOMATIC MONTHLY PAYMENT OPTION

FOR THOSE RECEIVING MILITARY RETIREMENT PAY OR MILITARY DISABILITY COMPENSATION

Now there is a very easy way to keep the premium payments for your valuable VGLI coverage up to date. You can have your payments deducted from your monthly retirement or disability pay automatically. There are several advantages to this option:

- No monthly check writing
- No late payments because you forgot to put it in the mail
- You save postage
- You save time

### Important information about using VGLI Pay By Allotment

Your allotment should begin about two (2) months after we receive this application in our office. To keep your account current during the set-up period, *please send two (2) monthly premium payments with this application.* It is important that you monitor your pay statements closely to ensure that premium payments for your VGLI coverage are deducted each month. If deductions are not shown on your pay statement by month three (3), contact us immediately.

#### 1.) Provide the following information:

Control Number: \_\_\_\_\_ Name: \_\_\_\_\_

#### 2.) Select one of the following:

- I authorize the Office of Servicemembers' Group Life Insurance to arrange for the payment of my Veterans' Group Life Insurance by allotment from my **Military Retirement Pay**.
- I authorize the Office of Servicemembers' Group Life Insurance to arrange for the payment of my Veterans' Group Life Insurance by allotment from my **Military Disability Compensation** payments.  
↳ Write your VA File Number here: \_\_\_\_\_

#### 3.) Read the paragraph below, then sign and date this form. Please write your daytime telephone number in the space provided so that we may contact you with any questions.

I understand that if for any reason, my Military Retirement Pay **or** Military Disability Compensation payments are not sufficient to pay my premium **in full**, or if this allotment is delayed, it is my responsibility to make payments directly to the Office of Servicemembers' Group Life Insurance (OSGLI).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Telephone Number