

Request for Family Coverage

Part I - To Be Completed By Member

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| 1. First Name - Middle Name - Last Name - Suffix | 2. Social Security Number | 3. Branch of Service |
| 4. Amount of SGLI Now In Force | 5. Amount of Coverage Desired for Spouse | |
| I understand that if I fail to furnish satisfactory evidence of my spouse's insurability, the fact that withholdings have been made from my pay for the insurance being requested will not create any liability for insurance, and that I will be entitled to appropriate credit for such withholdings. | | |
| 6. Signature of Servicemember | 7. Date (dd-mmm-yyyy e.g. 12-NOV-2001) | |

Part II - To Be Completed By Spouse

| | | |
|---|---------------------------|---|
| 8. First Name - Middle Name - Last Name - Suffix | 9. Social Security Number | 10. Date of Birth (dd-mmm-yyyy e.g. 12-NOV-2001) |
| 11. <input type="checkbox"/> Weight (lbs) <input type="checkbox"/> | 12. Height (ft & ins) | 13. Gender Male Female |
| | Yes No | Yes No |
| 14. Have you ever been diagnosed as having a disease or disorder of the immune system? | | C. Nervous disorder? |
| 15. Have you had or been treated for known indications of : | | D. Diabetes? |
| A. A heart condition? | | E. Cancer or tumors? |
| B. High blood pressure? | | 14. Do you have any known physical or mental impairments, deformities, or ill health not covered above? |
| 17. If your answer to any part of items 12 through 14 is yes, please refer to item number and give dates, duration and other details. (If more space is needed, attach a separate sheet) | | |
| The answers I have given are for securing approval of this request for insurance and I certify that they are true and correct to the best of my knowledge and belief. I understand that the insurance being requested requires approval of insurability by the Office of Servicemembers' Group Life Insurance. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim. | | |
| 18. Signature of Spouse | 19. Mailing Address | 20. Date (dd-mmm-yyyy e.g. 12-NOV-2001) |

Part III – To Be Completed By Member’s Commanding Officer (or designee)

I certify that the signature in Part I above is that of the member named and according to the records of this department, this member is eligible to apply for the amount of family coverage requested above.

| | | |
|--|--------------------------------------|---|
| 21. Name of Commanding Officer or designee (please print) | 22. Organization and Mailing Address | 23. Rank, Title or Grade |
| 24. Signature of Commanding Officer or designee | | 25. Date (dd-mmm-yyyy e.g. 12-NOV-2001) |
| For OSGLI Use Only | | |
| <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove | Signature of OSGLI Representative | Date (dd-mmm-yyyy e.g. 12-NOV-2001) |

INSTRUCTIONS - PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM

Use this form to apply for:

- Family Coverage for your spouse if you previously cancelled or declined coverage, or
- An increase in the amount of Family Coverage for your spouse, if he/she has less than the maximum amount.

TO MEMBER - Complete Part I by typing or printing in ink and sign your name. The maximum amount of coverage you can have on your spouse is \$100,000 or an amount equal to your Servicemembers’ Group Life Insurance, whichever is less. Have your spouse complete and sign Part II. Then submit the form for completion by your Commanding Officer. If this request is accepted, the insurance will be effective on the first day of the month following completion of this form. Premiums will automatically be deducted from your pay.

TO UNIFORMED SERVICE - Parts I and II should be completed by the member and the member’s spouse when you receive it. It should then be certified in Part III by his/her Commanding Officer, equivalent superior or designee.

If the spouse answers “NO” to Item 14, all parts of Item 15 and to Item 16, the completed form should be retained in the member’s personnel file. Once this is done, action should be initiated to deduct premiums from the member’s pay. It is not necessary to send a copy of this form to the Office of Servicemembers’ Group Life Insurance (OSGLI) for approval.

If the spouse answers “YES” to Item 14, any part of Item 15, or to Item 16, he/she should also have completed Item 17. A copy of the completed form should be sent to:

Office of Servicemembers’ Group life Insurance
80 Livingston Avenue
Roseland, NJ 07068-1733

Upon receipt, OSGLI will review the application and return an annotated copy to the member’s organization showing whether the request is approved or disapproved. The copy returned from OSGLI is to be filed in the member’s personnel file. No action should be taken to deduct the premium from the member’s pay until the “APPROVED” form is received from OSGLI. At this time, the premium deduction should begin with the pay for the month when a servicemember elects to have their spouse covered. (Note: If the spouse dies between the time the form is submitted to OSGLI and the time it is returned marked “APPROVED,” the insurance will be paid. If the form is returned marked “DISAPPROVED,” the insurance will not be paid.) If the request for insurance is disapproved, OSGLI will return the form with a letter of explanation to the Commanding Officer. The member should be notified that he/she may write to OSGLI or telephone them at 1-800-419-1473 for further explanation.