Prudential

Office of Servicemembers'
Group Life Insurance

Office of Servicemembers' Group Life Insurance
P.O. Box 41618
Philadelphia, PA
19176-9913

800-419-1473
Contact Center
Toll free, worldwide

Apply Online at **www.insurance.va.gov**

DEAR VETERAN,

PLEASE FOLLOW THE INSTRUCTIONS BELOW TO APPLY FOR REINSTATEMENT OF YOUR VETERANS' GROUP LIFE INSURANCE (VGLI) COVERAGE .

Application for Reinstatement of Veterans' Group Life Insurance

SECTION 1 - VETERAN INFORMATION

Please provide all requested information.

SECTION 2 - CERTIFICATION OF HEALTH

Complete Section 2 if your lapse date is **less than 6 months ago**. You do not need to complete the health questions in Section 3 if your lapse date is less than 6 months ago.

SECTION 3 - CERTIFICATION OF HEALTH

Complete Section 3 if your lapse date is **more than 6 months ago.**

SEND YOUR COMPLETED APPLICATION TO:

Office of Servicemembers' Group Life Insurance
P.O. Box 41618
Philadelphia, PA
19176-9913

REINSTATEMENT AMOUNT

The reinstatement amount is equal to three (3) times your monthly premium (based on the insured's current age). For questions, please call the contact center at 800-419-1473, Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time, Toll Free, Worldwide.

You can also determine your premium online with the "premium calculator" at:
www.insurance.va.gov
Under "Online Policy Access" select "Apply for VGLI Online"

Thank you for your service.

Office of Servicemembers' Group Life Insurance

Ed. 03/2012

Prudential

Office of Servicemembers' Group Life Insurance

Veterans' Group Life Insurance

Application For Reinstatement Of Coverage

Control Number:

Lapse Date: MM - DD - YYYY

Apply for reinstatement online at:
www.insurance.va.gov

Coverage Amount: ,

Reinstatement Amount:
Must equal 3 months premium , .

1 VETERAN INFORMATION

First Name: MI:

Last Name:

Address 1:

Address 2:

City:

State: ZIP Code: - Country:

Phone Number: - -

Email:

You must check this box when the address is outside the United States. ☐

2 CERTIFICATION OF HEALTH

(Use Section 2 only when your Lapse Date is less than 6 months ago. Use Section 3 if your Lapse Date is longer than 6 months ago.)

I am applying for reinstatement of my insurance in the amount shown above. As a condition to the reinstatement of this insurance, I certify that to the best of my knowledge and belief, I am now in as good health as I was on the date of the insurance lapse.

SINCE THAT DATE, I have not been ill or suffered or contracted any disease, infirmity, or any injury, nor have I been prevented by reason thereof from attending to my usual occupation, nor have I consulted a physician, surgeon, or other practitioner for medical advice or treatment at home, hospital, or elsewhere in regard to my health, except as shown below. This statement refers to all disabilities including any service-connected disabilities.

EXCEPTION: Describe any illness, disease, injury or medical treatment with dates since the lapse date. Also, give the names addresses of all doctors, other practitioners and /or hospitals concerned. Please use remarks below for details.

Remarks:

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.

X

Veteran's Signature:

Date: MM - DD - YYYY

Prudential

Office of Servicemembers' Group Life Insurance

Veterans' Group Life Insurance

Application For Reinstatement Of Coverage

Apply for reinstatement online at: www.insurance.va.gov

Control Number: ☐☐☐☐☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3 CERTIFICATION OF HEALTH

(Use Section 3 only if your Lapse Date is more than 6 months ago. Use Section 2 if your Lapse Date is less than 6 months ago.)

Height: ☐ feet ☐☐ inches Weight: ☐☐☐ pounds

Have you had or been treated for or had known indications of:

		Y	N
A.	Heart trouble or abnormal pulse?	☐	☐
B.	High blood pressure?	☐	☐
C.	Diabetes or sugar in urine?	☐	☐
D.	Cancer or tumors?	☐	☐
E.	Lung or respiratory disorders?	☐	☐
F.	Disorders of kidney, bladder or urinary system?	☐	☐
G.	Disorders of the liver or gall bladder?	☐	☐
H.	Disorders of stomach or intestines?	☐	☐
I.	Arthritis?	☐	☐

In the past 5 years have you:

		Y	N
J.	Been declined or postponed for any form of life or health insurance or offered a policy with a higher premium because of health reasons only?	☐	☐
K.	Been absent from work for more than 5 continuous days because of sickness or injury?	☐	☐
L.	Been advised to have a surgical procedure?	☐	☐
M.	Been a patient or been advised to enter a hospital or health care facility?	☐	☐
N.	Consulted, been attended, or examined by a doctor or other practitioner other than annual or periodic physicals?	☐	☐
O.	Used barbiturates, heroin, opiates, or other narcotics, or been treated for alcoholism?	☐	☐
P.	Been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	☐	☐
Q.	Had any known physical impairments, deformities, or ill health not covered above?	☐	☐
R.	Do you have a service-connected disability?	☐	☐

If yes, what is the VA claim file number? ________________

Please provide details for all questions answered "yes." Use additional paper if necessary.

Question Number	Nature of Illness	Illness began Month/Year	Time lost from Normal Activities	Full Recovery Month/Year	Treating Physician's Name & Address

(Please attach a separate sheet with details for any question answered "yes")

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.

X ______________________________

Veteran's Signature:

Date: ☐☐ – ☐☐ – ☐☐☐☐
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