OMB Approved No. 2900-0016 Respondent Burden: 1 hour 45 minutes Expiration Date: 6-30-2015

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Department of Veterans Affairs

CLAIM FOR DISABILITY INSURANCE GOVERNMENT LIFE INSURANCE

PRIVACY ACT INFORMATION: 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 identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U.S. Government Life Insurance Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain this benefit. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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: We need this information to determine your eligibility for VA insurance benefits. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 45 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send your comments or suggestions about this form.

INFORMATION AND INSTRUCTIONS

THIS APPLICATION IS TO BE COMPLETED BY VETERANS WHO HAVE GOVERNMENT LIFE INSURANCE AND BECOME TOTALLY DISABLED.

TOTAL DISABILITY:

- 1. Any impairment of mind or body which makes it impossible for the veteran to be gainfully employed.
- 2. Total Disability must start before the veteran's 65th birthday.

WAIVER REFUND

- 1. Premium Refunds limited to one year prior to date the claim is filed, unless there were circumstances beyond the veteran's control (such as a severe mental disability). LACK OF KNOWLEDGE OF THE WAIVER PROVISION IS NOT A CIRCUMSTANCE BEYOND THE VETERAN'S CONTROL.
- 2. If total disability started more than one year prior to the date of your claim, and you believe a mental disability prevented you from filing an earlier claim, please include a statement explaining these circumstances on a separate sheet of paper. YOU SHOULD ALSO INCLUDE ANY MEDICAL EVIDENCE WHICH SUPPORTS YOUR STATEMENT.

PART I should be completed by the insured veteran if able; if not, by a person acting on his/her behalf.

PART II should be completed by the insured veteran's physician or hospital official. If there will be a delay in preparing Part II send Part I immediately.

NOTE: IF THE VETERAN HAS BEEN GRANTED DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION, PLEASE ATTACH A COPY OF THE AWARD LETTER.

PART I								
1. FIRST, MIDDLE, LAST NAME OF INSURED (Type or print)	2. INSURANCE FILE NUMBER (Include letter prefix)							
3. MAILING ADDRESS FOR INSURANCE PURPOSES (Number and Stree Route, City or P.O., State and ZIP Code)	et or Rural 4. SOCIAL SECURITY NUMBER							
	5. DATE OF BIRTH							
	6. DAYTIME TELEPHONE NUMBER (Include Area Code)							
	7. CLAIM NUMBER							
8. DATE DISABILITY PREVENTED EMPLOYMENT	9. DATE RETURNED TO GAINFUL EMPLOYMENT							
10A. EDUCATION (Check highest years completed) (If you have any other specialized training or education please complete Item 10B)								
	3 4 □ 1 □ 2 □ 3 □ 4							
	School) (College)							
10B. PLEASE PROVIDE ANY SPECIALIZED TRAINING IN THE SPACE P								
11. ARE YOU RECEIVING OR HAVE YOU APPLIED FOR ANY	12. DISEASE OR INJURY CAUSING TOTAL OR PERMANENT DISABILITY							
DISABILITY BENEFITS AS LISTED BELOW?								
☐ VA DISABILITY ☐ VA PENSION ☐ SOCIAL SECURITY ☐ DISABILITY								

IF YOU HAVE ANY QUESTIONS ABOUT DISABILITY BENEFITS OR YOUR INSURANCE, PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477							
13. HOSPITALS WHERE YOU HAVE BEEN TREATED, INCLUDING VA HOSPITALS							
NAME OF HOSPITAL ADDRESS OF HOSPITAL			DATE OF ADMISSION DATE OF RELEASI				
44 DUNG		VE TDEATED VOLUEOR DIOE 40E 0	ND INTERPO	IO TOTAL DE	DMANIENI	- DIOADH ITV	
14. PHYSICIANS WHO HAVE TREATED YOU FOR DISEASE OR INJURY, CAUSING							
NAME OF PHYSICIAN ADDRESS OF PHYSICIAN		DATE TREATMENT BEGAN		DATE OF LAST TREATMENT			
15. RECORD OF EMPLOYMENT FOR ONE YEAR PRIOR TO THE DATE OF TOTAL DISABILITY TO THE PRESENT (Include self-employment)							
DATES OF E	MPLOYMENT	LAST DAY INSURED WORKED	HOURS WOR	RKED		EARNINGS	
FROM	ТО	DATE	WEEKLY WEEKLY				
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	R	EASON FOR T	ERMINATIC	ON OF EMPLOYMENT	
DATES OF E	MPLOYMENT	LAST DAY INSURED WORKED	HOURS WOF	RKED		EARNINGS	
FROM	ТО	DATE	WEEKLY	WEEKLY			
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	R	EASON FOR T	ERMINATIC	ON OF EMPLOYMENT	
DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WOF	RKED	EARNINGS		
FROM	ТО	DATE	WEEKLY			WEEKLY	
OCCUPATION		NAME AND ADDRESS OF EMPLOYER	REASON FOR TERMINATION OF EMPLOYMEN		ON OF EMPLOYMENT		
I consent that any physician or hospital who has treated or examined me for any purpose, or who I have consulted professionally, any insurance company or organization to which I have applied for insurance, or any person, persons, firm or corporation to whom, or to which I have applied for employment or disability benefits, may provide to the Department of Veterans Affairs or testify as to, or produce in court, any information obtained concerning myself by reason of the foregoing, and waive any privileges which render such information confidential. A photostatic copy of this consent shall be considered valid authorization for release of information to VA. I certify that each question has been truthfully and completely answered to the best of my knowledge.							
16. DATE OF SIGNATURE 17. SIGNATURE OF INSURED (Or official or fiduciary completing form for insured)							
PENALTY - The law provides that whomever makes any statement of a material fact, knowing it to be false, shall be punished by fine or imprisonment or both.							

REPORT FOR DISABILITY INSURANCE PURPOSES OF TREATMENT IN A **PART II** HOSPITAL OR FROM AN ATTENDING PHYSICIAN Part II of this application should be completed by the appropriate hospital official or by the veteran's attending physician. If appropriate hospital summaries are available, please forward with application. 1. FIRST, MIDDLE, LAST NAME OF INSURED (Type or print) 2. INSURANCE FILE NUMBER (Include letter prefix) 3. HOME ADDRESS (Number and Street or Rural Route, City or P.O., State and ZIP Code) FOR VA USE ONLY 4. CLAIM NUMBER 5. SOCIAL SECURITY NUMBER 6. HISTORY (Conditions causing disability) A. WHEN DID INJURY OR ILLNESS BEGIN? B. DATE INSURED STOPPED WORKING BECAUSE OF DISABILITY C. DATE OF FIRST TREATMENT D. FREQUENCY AND NATURE OF TREATMENT E. OBJECTIVE SYMPTOMS AND FINDINGS WHEN FIRST SEEN F. DIAGNOSIS. INCLUDE RESULTS OF SPECIAL STUDIES 7. HOSPITALIZATION DATE NAME AND ADDRESS OF HOSPITAL CONDITION AT DISCHARGE FROM TO 8. PROGNOSIS A. DATE OF LAST EXAM OR TREATMENT B. OBJECTIVE FINDINGS C. DIAGNOSIS - CONDITIONS CAUSING DISABILITY D. IS VETERAN CAPABLE OF DOING ALL OF HIS/HER WORK? ☐ YES ☐ NO E. IS VETERAN CAPABLE OF DOING ANY OTHER WORK? ☐ YES ☐ NO F. CARDIAC FUNCTION (Check if applicable) AHA FUNCTIONAL CAPACITY - CL 1 (NO LIMITATION) AHA FUNCTIONAL CAPACITY - CL 3 (MARKED LIMITATION) AHA FUNCTIONAL CAPACITY - CL 2 (SLIGHT LIMITATION) AHA FUNCTIONAL CAPACITY - CL 4 (COMPLETE LIMITATION) G. MENTAL/NERVOUS IMPAIRMENT (Ability to function in stressful situations and engage in H. SINCE FIRST TREATMENT HAS VETERAN interpersonal relations) (Check if applicable) REMAINED ☐ IMPROVED ☐ WORSENED [NO SLIGHT MODERATE LIMITATION LIMITATION SEVERE LIMITATION ☐ MARKED LIMITATION THE SAME 9. NAME AND ADDRESS OF ATTENDING PHYSICIAN OR HOSPITAL 10. DATE OF REPORT 11. SIGNATURE AND TITLE OF PERSON PREPARING REPORT When completed and signed, send this claim form IMMEDIATELY to the office of the Department of Veterans Affairs where the Insurance Records are maintained. The address of the Department of Veterans Affairs office that maintains these records is: Department of Veterans Affairs Regional Office and Insurance Center (WP) P.O. Box 7208 Philadelphia, PA 19101