Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI)

A Procedural Guide

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Part 1 - General Provisions of TSGLI

General Information

The Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program is an automatic provision under Servicemembers Group Life Insurance (SGLI). TSGLI provides for payment to Servicemembers who are severely injured (on or off duty) as the result of a traumatic event and suffer a loss that qualifies for payment under TSGLI. TSGLI is designed to help traumatically injured Servicemembers and their families with financial burdens associated with recovering from a severe injury. TSGLI payments range from $25,000 to $100,000 based on the qualifying loss suffered. The benefit is paid to the member, someone acting on the member's behalf if the member is incompetent, or the members' SGLI beneficiary if the member is deceased. TSGLI coverage was added to SGLI policies effective December 1, 2005. All members covered under SGLI who experience a ***traumatic event*** that directly results in a ***traumatic injury*** causing a ***scheduled loss*** defined under the program are eligible for TSGLI payment.

Basic Definitions

There are several terms that are key to the TSGLI program. These terms are defined below. If TSGLI Branch of Service Certifying Officials have specific questions on TSGLI claims that deal with these issues, they should contact the Chief, Program Administration and Oversight Staff at the Veterans Affairs Insurance Center (see Appendix C for contact information.)

External Force - An external force is a force or power that causes an individual to meet involuntarily with an object, matter, or entity that causes the individual harm. There is a distinct difference between ***internal*** and ***external*** forces. "***Internal forces***" are forces acting between body parts, and "***external forces***" are forces acting between the body and the environment, including contact forces and gravitational forces as well as other environmental forces.

Traumatic Event - A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to the body.

The event must involve a physical impact upon an individual. Some examples would include: an airplane crash, a fall in the bathtub, or a brick that falls and causes a sudden blow to the head. It would not include an injury that is induced by the stress or strain of the normal work effort that is employed by an individual, such as straining one's back from lifting a ladder.

Physical impacts do not require penetrating injuries to occur. Non-penetrating blast injuries, such as those common with the use of improvised explosive devices that cause concussive injuries, still involve external force and violence from the power of the blast coming into contact with an individual.

Exposure to the elements includes heat stroke and frostbite. In such cases the severe exposure to the heat and cold are traumatic events in and of themselves. For example, being diagnosed with heat stroke after collapsing during a physical training run in scorching temperatures would be a traumatic event.

Direct Result– Direct result means there must be a clear connection between the traumatic event and resulting loss and no other factor, aside from the traumatic event can play a part in causing the loss.

Traumatic Injury - A traumatic injury is the physical damage to your body that results from a traumatic event.

Scheduled Loss - A scheduled loss is a condition listed in the TSGLI Schedule of Losses if that condition is directly caused by a traumatic injury. The Schedule of Losses lists all covered losses and payment amounts (see Appendix A, Schedule of Losses).

Eligibility for TSGLI

All members of the uniformed services who have full-time or part-time Servicemembers' Group Life Insurance (SGLI) are automatically covered by TSGLI while the member is in service. For those who suffered an injury between October 7, 2001 and November 30, 2005 that resulted in a qualifying loss, members are covered by TSGLI regardless of whether they had SGLI coverage at the time of their injury. TSGLI coverage automatically ends upon the member's separation or release from service or the member's declination of SGLI coverage. Spouses and children covered under Family SGLI are not covered by TSGLI.

Coverage Periods for Full-Time and Part-Time TSGLI

In general, members are covered under TSGLI for the same periods they are covered under SGLI. The only exception is that TSGLI coverage ends on the date the member separates from service, while SGLI coverage continues for a minimum of 120 days after the member separates from service. There are two situations that govern the TSGLI coverage period.

1) Member is covered under full-time SGLI
2) Member is covered under part-time SGLI

1) Member is Covered Under Full-time SGLI

When a member is covered under full-time SGLI, the member's TSGLI coverage is full-time as well. This means the member is covered under TSGLI 24 hours per day, 365 days per year, both on and off duty. A Servicemember is covered under full-time SGLI and therefore full-time TSGLI if the member meets one of the following conditions:

- The member performs active duty or active duty for training under a call or orders that specifies 31 days or more OR
- The member is a Ready Reservist who is assigned to a unit in which the member is scheduled to drill at least 12 times during the year. This includes members who are drilling for pay and members who are drilling for retirement points.

2) Member is Covered Under Part-time SGLI

When a member is covered under part-time SGLI, the member's TSGLI coverage is part-time as well. Part-time TSGLI covers the member only during the actual days of duty and while proceeding directly to and returning directly from their scheduled duty. A member is covered under part-time SGLI and therefore part-time TSGLI if the member meets one of the following conditions

- The member is a Ready Reservist who is under a call or order that specifies less than 31 days OR
- The member is a Ready Reservist who is not scheduled to drill at least 12 times during the year.

Note: Members eligible for part-time coverage become eligible for full-time coverage when they perform active duty or active duty for training, under calls or orders that specify 31 days or more.

When Coverage Begins

SGLI and TSGLI coverage begin automatically for Servicemembers who enter onto active duty or Ready Reserve service. Entry onto active duty or Ready Reserve service is defined as follows:

- A civilian who enlists for regular active duty
- A civilian who enlists in the Ready Reserve
- A Ready Reservist who is mobilized to active duty status
- A Ready Reservist who is demobilized and returns to reserve status
- A member who completes active duty and is assigned to the Ready Reserve

Qualifying for TSGLI Payment

Basic Requirements

In order to qualify for TSGLI payment, a member must meet all of the following requirements:

1) The member must suffer a scheduled loss (see Part 4, Scheduled Losses) that is a direct result of a traumatic injury due to a traumatic event and no other cause.
2) The member must have suffered the traumatic event before midnight of the day that the member separates from the uniformed services*
3) The member must suffer the scheduled loss within two years (730 days) of the traumatic event**.
4) The member must survive for a period of at least seven full days from the date of the traumatic event. The seven-day period begins on the date and time of the traumatic event, as measured by Zulu (Greenwich Meridian) time and ends 168 full hours later.
5) If injured on or after December 1, 2005, the member must be insured by SGLI at the time of the traumatic event. If injured from October 7, 2001 through November 30, 2005, the member does not need to be insured under SGLI to qualify for a TSGLI payment.

**Note 1: The scheduled loss may occur subsequent to the date of termination of duty status in the uniformed services, provided it is within two years of the traumatic event.*

***Note 2: See notes under each of the Scheduled Losses listed below for an explanation of how the 730- day limitation period is applied to that loss:*

- *Coma*
- *Loss of ADL due to Traumatic Brain Injury(TBI) or Other Traumatic Injury (OTI)*
- *Hospitalization due to TBI or OTI*

Injuries Excluded From TSGLI Payment

The following injuries are excluded from TSGLI payment:

1) Injuries caused by one of the following:
   a) A mental disorder
   b) A mental or physical illness or disease, (not including illness or disease caused by a pyogenic infection, biological, chemical, or radiological weapon, or accidental ingestion of a contaminated substance.)
   c) Attempted suicide
   d) Intentionally self-inflicted injury or an attempt to inflict such injury
   e) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment.
   f) The members' willful use of an illegal or controlled substance, unless administered or consumed on the advice of a medical professional.
2) Injuries sustained while committing, or attempting to commit, a felony.

Certain exclusions and terms above warrant additional explanation.

Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment.

Any loss arising from diagnostic procedures or medical and surgical treatments and complications from illness or disease, rather than a traumatic injury, are not covered.

> Example 1: diagnosis of an illness or disease: A member goes to the hospital for a routine colonoscopy. Due to medical error, the patient is injured and must remain in the hospital for 15 days. The member's loss is not covered by TSGLI.
>
> Example 2: medical or surgical treatment for an illness or disease: A member has diabetes and her condition begins to cause problems to her leg resulting in the amputation of her leg. The member's loss is not covered by TSGLI because it was the result of treatment for an existing condition.
>
> Example 3: complications arising from medical or surgical treatment: A member undergoes heart bypass surgery. During the surgery, the member's aorta is nicked and the member must remain in the hospital for an additional 15 days. The member's loss is not covered by TSGLI because it was the result of complications arising from medical treatment.
>
> Example 4: routine medical treatment: A member is given a routine vaccination, has a severe reaction to the vaccination, and goes into a coma for 15 days. The member's loss is not covered by TSGLI

However, a loss arising from complications of necessary surgery to treat a traumatic injury are covered. These situations are not excluded under the medical or surgical treatment exclusion above because the surgery was required due to a traumatic injury, not simply the result of treatment of an illness or disease.

> Example, surgical treatment of a traumatic injury: A member's vertebra is fractured in a mortar blast in Iraq. While undergoing surgery for the fractured vertebrae, a blood clot forms during the surgery on the member's back, causing the member to be paralyzed from the waist down. The member's loss is covered by TSGLI.

Pyogenic infection - a pyogenic infection is a pus forming infection, often caused by a wound.

> Example: A member is injured in a car accident. She suffers injuries to her leg. Unfortunately, her wounds develop a pus-forming infection (pyogenic infection) and spread gangrene up her leg resulting in the loss of her leg. The member's loss would be covered by TSGLI.

Chemical Weapon - a chemical substance intended to kill, seriously injure, or incapacitate humans through their physiological effects.

> Example: A member is hit with the materials from a chemical weapon. He develops an illness that causes the deterioration of his retinas resulting in the loss of his vision. The member's loss would be covered by TSGLI.

Radiological Weapon - radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

> Example 1: A member is searching for weapons and finds a cache of nuclear weapons and is exposed to radiation. The member suffers nerve damage and is unable dress and transfer for 120 days. The member's loss would be covered under TSGLI.

Example 2: A member is exposed to radiation while working at an Army weapons depot and is accidentally exposed to radiation. The member subsequently develops cancer and has to have his leg amputated. The members' loss would be covered by TSGLI

Biological Weapon – biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects

See examples under, "Radiological Weapon"

Contaminated Substance - food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

Example: A member serving in Iraq is involved in a skirmish with enemy forces. He is forced to wait out the enemy for three days in a remote area. He only has a one-day supply of water. In order to survive, he drinks water from a small stream nearby. After escaping from his hiding place, the member returns to his base and becomes ill with vomiting, diarrhea, and a fever. After a number of days with these symptoms, the member falls into a coma for 20 days. It is determined that the illness causing the coma was a result of drinking contaminated water from the stream. The member's loss would be covered by TSGLI.

Amount Payable Under TSGLI

The maximum amount payable under TSGLI for all injuries resulting from a single traumatic event is $100,000. There are three scenarios that govern payments under TSGLI:

1) A single injury resulting from a single traumatic event
2) Multiple injuries resulting from a single traumatic event
3) Multiple injuries resulting from multiple traumatic events

1) A Single Injury Resulting From a Single Traumatic Event

When a member suffers an injury from a single traumatic event, the member's TSGLI benefit will be the amount payable for that injury listed on the schedule of losses up to a maximum of $100,000.

2) Multiple Injuries Resulting From a Single Traumatic Event

When a member suffers multiple injuries from a single traumatic event, the member's TSGLI benefit will be the amount for the highest paying scheduled loss up to a maximum of $100,000. Certain injuries can be combined and treated as a single scheduled loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

Example: A member permanently loses sight in both eyes due to a traumatic event on April 1, 2012. The benefit under the schedule for permanent loss of sight in both eyes is $100,000. The member loses one foot May 1, 2012, as a direct result of a traumatic injury of the same traumatic event. The benefit under the schedule for the loss of one foot is $50,000. The member will be paid $100,000 for permanent loss of sight, which is the higher paying scheduled loss.

3) Multiple Injuries Resulting From Multiple Traumatic Events

When a member suffers multiple injuries from multiple traumatic events, these events can be broken down into two categories, multiple traumatic events that occur within a seven-day period and multiple traumatic events that occur more than seven full days apart.

a) Multiple traumatic events that occur within a seven-day period

Multiple traumatic events that occur within seven days are treated as a single event. This seven-day period begins with the day on which the first traumatic event occurs. The member's TSGLI benefit will be the amount for the highest paying scheduled loss up to a maximum of $100,000. Certain injuries can be combined and treated as a single schedule loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

> Example: A member loses a foot as a result of an IED explosion on Jan 1, 2012. On January 2, 2012, the vehicle transporting the injured member is involved in an accident. As a result of the accident, the member permanently loses sight in both eyes. The loss of sight carries a scheduled benefit of $100,000 and the loss of 1 foot carries a scheduled benefit of $50,000. Since the two traumatic events occurred within seven days of one another they are treated as a single event. The member's TSGLI benefit will be $100,000 for permanent loss of sight, which is the higher paying scheduled loss.

b) Multiple traumatic events that occur more than seven full days apart

Multiple traumatic events that occur more than seven full days apart are treated as separate events, and the injuries from each event are evaluated individually. The member's TSGLI benefit will be the amount for the highest paying scheduled loss ***from each event*** up to a maximum of $100,000 ***for each event***. Certain injuries can be combined and treated as a single scheduled loss and others cannot (See Part 4, Schedule of Losses, for information about combining injuries).

> Example: A member loses sight in both eyes on May 1, 2012 as the result of a civilian motorcycle accident. The member submits an application for the loss of sight on May 30, 2012. The member is paid $100,000 for the loss of sight.
>
> The same member loses one foot due to an automobile accident that occurred on November 1, 2012. The member submits a second application for the second loss on December 1, 2012. Since the second event is more than 7 full days after the first event, the member is paid an additional $50,000 for the loss of one foot. The member's total TSGLI benefit is $150,000.

TSGLI Premiums

The premium for TSGLI is a flat rate of $1 per month for both Active duty and Ready Reserve members with full-time SGLI coverage. Members with part-time coverage and members on funeral honors or one-day muster duty will pay the premium indicated in the table below.

Duty Status	Premium
Reservists w/part-time SGLI coverage	$1.00 per year
Funeral honors & 1 day muster duty	No charge

Note: These rates are determined by VA and are subject to change based on claims experience.

Part 2 –Ending TSGLI Coverage

General Information

The member cannot choose to decline TSGLI coverage only, nor can the member elect TSGLI coverage without SGLI coverage. TSGLI coverage is automatic for those members insured under SGLI. However, if the member declines SGLI, he or she is also declining TSGLI coverage.

TSGLI coverage will end due to any event that causes the member's SGLI coverage to end.

Ending TSGLI Coverage

TSGLI coverage ends due to the following events:

1) Member elects to decline SGLI coverage (SGLV form 8286)
2) Member is released from service
3) Member dies

1) Member Elects to Decline SGLI Coverage

When a member declines SGLI coverage by completing a SGLV Form 8286, the member's SGLI coverage and TSGLI coverage stay in effect until midnight of the last day of the month in which the member declines coverage. A premium for TSGLI is due for the month in which the member declines coverage. No further premiums are due until such time as the member restores SGLI coverage.

> Example: The member submits SGLV Form 8286 to the unit on the 15th of the month to decline SGLI coverage. A premium is deducted from the member's pay for both SGLI and TSGLI for that month. The member loses a leg as a result of a car accident on the 25th of the same month. The member is still covered under TSGLI and will receive payment of $50,000 for the loss of the leg.

2) Member Separates From Service

When a member separates or is released from service, TSGLI coverage stays in effect until midnight of the day of release. TSGLI coverage is not in effect during the 120-day post-separation period nor during the 2-year SGLI Disability Extension. A premium is due for the month in which the member is released. No further premiums are due.

3) Member Dies

When a member dies, a premium for TSGLI and SGLI is due for the month of the death. No further premiums are due.

Part 3 –Restoring TSGLI Coverage

General Information

The member can restore TSGLI coverage by restoring SGLI coverage. To restore SGLI, and therefore TSGLI, the member must complete SGLV Form 8286. The "good health" of the member is an issue in being eligible to restore SGLI coverage. The health questions on SGLV Form 8286 must be answered.

Restoring TSGLI Coverage

TSGLI coverage can be restored, after it has been ended, when one of the following events occurs:

1) Member's change in duty status* begins automatic maximum coverage
2) Member elects to restore SGLI coverage

*A "change in duty status" is defined as follows:

- A Ready Reservist who is mobilized to active duty status
- A Ready Reservist who is demobilized and returns to reserve status
- A member who completes active duty and is assigned to Ready Reserve

1) Member's Change in Duty Status Begins Automatic Maximum Coverage

After a member has declined SGLI coverage, and therefore TSGLI, a change in duty status will automatically begin both SGLI at the maximum level and TSGLI coverage. The member is not required to complete SGLV Form 8286 in this situation.

2) Member Elects to Restore SGLI Coverage

After a member has declined SGLI coverage, and therefore TSGLI coverage, he/she must complete a SGLV Form 8286 in order to restore his/her SGLI. TSGLI coverage is automatically restored if and when the Service Member's restoration of SGLI coverage is approved.

The member must answer all of the health questions on the form. If the member answers "Yes" to any of the health questions, the unit should refer the election to the Office of Servicemembers' Group Life Insurance (OSGLI) for a decision on coverage. No premiums for SGLI and TSGLI are due until OSGLI determines coverage is approved. If coverage is approved, premiums are due back to the month the election was received by the service.

Example: The member previously declined SGLI coverage, and therefore TSGLI coverage as well. The Service Member's election to restore SGLI coverage is received on February 8th. Assuming all health questions are answered as "No", the premium deduction begins immediately with the February pay. If the member answers "Yes" to any health questions, OSGLI must approve the coverage before premiums begin. If OSGLI approves the coverage in March, premiums are collected for both February and March.

Part 4 –Schedule of Losses

General Information

A scheduled loss is a loss that is suffered as a result of a traumatic event and is listed on the schedule of losses. The Schedule of Losses (see Appendix A) outlines the injuries covered under TSGLI and the amount payable for each injury. Certain injuries listed in the schedule may be combined and treated as a single scheduled loss. Payments range from a minimum of $25,000 to a maximum of $100,000. This section is a guide for using the schedule to combine injuries as a single loss, evaluating the type of loss suffered and determining the TSGLI benefit payment amount.

Using the Schedule to Combine Injuries as a Single Loss

When a member suffers multiple injuries from a single traumatic event, the member's TSGLI benefit will be the amount for the highest paying loss listed on the Schedule of Losses up to a maximum of $100,000. Certain injuries can be combined and treated as a single schedule loss and others cannot.

The Schedule of Losses is divided into two parts.

1) Part 1 – Injuries that MAY be combined as a single loss
2) Part 2 – Injuries that MAY NOT be combined as a single loss

1) Part I – Injuries that MAY be combined as a single loss

Part 1 lists injuries that may be combined with each other and treated as a single scheduled loss (except where noted otherwise). The total payment amount may not exceed $100,000.

Example 1: combining injuries as a single loss: A member is injured in a car accident. As a result, her hand is amputated and she suffers uniplegia (paralysis of one leg). Since these injuries are listed on Part 1 of the schedule, they can be combined as a single loss. The member's payment would be $50,000 for amputation of hand and $50,000 for uniplegia of one leg for a total payment of $100,000.

Example 2: paying the maximum scheduled benefit: A member is injured in an IED blast. The member suffers 2nd degree burns to 20% of his body, which has a scheduled payment of $100,000. The member also suffers the loss of hearing in one ear which has a scheduled payment of $25,000. Although both injuries are listed in Part 1 of the schedule, the member cannot receive more than $100,000 as the result of a single traumatic event. Therefore, the member would receive $100,000 for burns.

Example 3: Part 1 injuries that cannot be combined: A member is injured in a motorcycle accident. The member suffers amputation of one foot. Although Part 1 lists amputation of foot, amputation of all toes on one foot, and amputation of big toe on one foot as separate injuries, the schedule indicates that these injuries cannot be combined with each other. Therefore the member would receive $50,000 for loss of foot.

Example 4: Multiple Part 1 Injuries suffered within a 2-year period: A member is injured in an automobile accident. The member suffers injuries to both her feet, and her left foot is amputated in July 2012. The member files a TSGLI claim and is paid $50,000 for amputation of her left foot. In September 2012, the member develops complications with the injuries to her right foot and has to have her big toe amputated. Since both injuries are listed in Part 1 of the schedule and the member has not received the maximum TSGLI payment of $100,000, the member files a second TSGLI claim and is paid $25,000 for loss of big toe.

2) Part II – injuries that MAY NOT be combined as a single loss

Part 2 lists injuries that cannot be combined with injuries in Part 1 or with each other. If the member has multiple injuries that are listed in both parts of the schedule, the member will receive payment for the highest paying loss up to a maximum of $100,000.

Example 1: A member is injured in a car accident. The member suffers an injury to her abdomen that results in the inability to perform Activities of Daily Living (ADL) for 30 days. The member also has one hand amputated. Since injuries listed in Part 2 cannot be combined with injuries listed in Part 1, the member will receive $50,000 for the amputation of her hand as this is the highest paying loss.

Example 2: A member is injured in an IED blast. The member suffers loss of hearing in one ear and injuries to both hands that result in the inability to perform Activities of Daily Living (ADL) for 60 days. Since injuries listed in Part 2 cannot be combined with injuries listed in Part 1, the member will receive $50,000 for the loss of ADL for 60 days as this is the highest paying loss.

Evaluating Loss(es) Suffered

Losses must meet the TSGLI standard in order to be eligible for a benefit payment. This section is a guide to evaluating these losses. There are 9 categories of losses covered.

1) Sensory Losses
2) Burns
3) Paralysis
4) Amputation
5) Limb Salvage
6) Facial Reconstruction
7) Activities of Daily Living (ADL)
8) Inpatient Hospitalization
9) Genitourinary Losses

1) Sensory Losses

There are three sensory losses covered under TSGLI: loss of sight, loss of hearing and loss of speech.

a) *Total and permanent loss of sight OR loss of sight that has lasted 120 days*

When a member has a loss of sight, the member is eligible for a TSGLI benefit for total and permanent loss of sight if the member meets one of the following three standards:

	If the member's visual acuity in at least one eye is…	**And their peripheral vision in at least one eye is…**	**And the loss of vision …**
1.	20/200 or less (worse) with corrective lenses	N/A	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.
2.	Greater (better) than 20/200 with corrective lenses	a visual field of 20 degrees or less	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.
3.	Non-existent due to complete loss of the eye(s)	N/A	N/A

b) Total and permanent loss of hearing

When a member has a loss of hearing, the member is eligible for a TSGLI benefit for total and permanent loss of hearing if the member meets the following standard:

If the member's average hearing threshold sensitivity for air conduction in at least one ear is…	and the loss of hearing will…
80 decibels or more	not improve (with reasonable certainty) throughout the member's life.

Hearing Acuity - Hearing acuity must be measured at 500 Hz, 1000 Hz and 2000 Hz to calculate the average hearing threshold. Loss of hearing must be clinically stable and unlikely to improve.

c) Total and permanent loss of speech

When a member has a loss of speech, the member is eligible for a TSGLI benefit for total and permanent loss of speech if the member meets the following standard:

If the member suffers…	and the loss of speech will…
An organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech). *	not improve (with reasonable certainty) throughout the member's life.

*If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.

2) Burns

When a member suffers burns, the member is eligible for a TSGLI benefit for burns if the member meets one of the following two standards:

If the member suffers…	over …
1. 2nd degree (partial thickness) or worse burns	20% of the body including the face and head
2. 2nd degree (partial thickness) or worse burns	20% of the face only

Note: Percentage may be measured using the Rule of Nines or any other acceptable alternative

Facial Burns Calculator: This calculator converts head burns as a percentage of Total Body Surface Area (TBSA) into a percentage of the face alone. It allows you to determine if a member meets the standard of 2nd degree burns to 20% of the face.

To calculate the percentage of the face burned:

Enter the percentage TBSA of the head on the Burn Chart: %

The total percentage of the face burned is:

The calculations are based on the following logic:

1. To obtain an approximation of the total burns to the face as a percentage of TBSA, divide the TBSA percentage for the head in half. (In simpler terms, the face is about half of the head.)

2. Now convert the TBSA percentage of the face that has been burned to a percentage of the face alone. To do this, use the Rule of Nines, the Brooke Army Medical Diagnostic Assessment or any other acceptable alternative. With these tools, the face is considered to be approximately 3.5 percent of TBSA. This does not include the neck.

Example: TBSA of the head burned is 5% on Burn Chart. Divide in half to get 2.5% TBSA of face burned. Then, take 2.5% TBSA of the face as part of the body and divide by 3.5%, the portion of the TBSA that is the face (without neck included),obtaining 71% of the face is burned.

Note 1: This calculator is based on the face being approximately 1/2 of the head. If the member in question has burns on the head that are mostly on the back of the head, not the face, you will need to estimate how much of the face is burned as compared to TBSA of the head and divide by that number instead of by 2.

Example: While TBSA of head is 4%, the burn chart shows approximately 75% of the burns are located on the back of the head. This would mean that you would need to use 1% TBSA of the head for placement in the burn calculator above - 25% of 4.

Note 2: TBSA of the head based on the Rule of Nines or similar tools cannot be more than 9%.

Note 3: This calculator is not applicable for calculating burns as a percentage of the entire body to determine if the member meets the standard of 2nd degree burns over 20% of the entire body. In this case, simply use the total TBSA provided on the Burn Chart.

Road Rash: The medical field considers road rash a deep skin abrasion due to the scraping of skin on hard surfaces. While road rash may be treated at a Burn Center for wound care, it is not a burn. Members suffering from road rash due to a traumatic event should not claim burns on their TSGLI application, but identify other losses covered under TSGLI for which they qualify.

Example: A member is injured when his motorcycle slides on a wet road. He has deep skin abrasions, termed road rash, on his arms and legs. He undergoes wound care at a local Burn Center. He is unable to perform bathing and dressing for 30 days after his accident. The member does not qualify for payment under burns but does qualify for $25,000 for the inability to perform two ADL for 30 days.

3) Paralysis

When a member is paralyzed, the member is eligible for a TSGLI benefit for paralysis if his/her loss meets the following standard:

If the member suffers…	AND paralysis fall into one of these four categories
Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain.	**Quadriplegia** - paralysis of all four limbs* **Paraplegia** - paralysis of both lower limbs* **Hemiplegia** - paralysis of the upper and lower limbs* on one side of the body **Uniplegia**- paralysis of one limb*

**A limb is defined as an arm or a leg with all its parts.*

4) Amputation

There are 4 amputation losses listed on the schedule. The TSGLI standard for each of these losses is listed below.

a) *Amputation of hand*

When a member loses a hand, the member is eligible for a TSGLI benefit for loss of hand if the member's hand is amputated at or above* the wrist.

**The words "at or above" in the standard refers to the loss being closer to the body.*

b) *Amputation of fingers*

When a member loses four fingers on the same hand or the member loses one thumb, the member is eligible for a TSGLI benefit for amputation of fingers if the member meets the following standard:

If the member suffers…	OR the member suffers…
Amputation of four fingers on the same hand (not including the thumb) at or above* the metacarpophalangeal joint	Amputation of thumb at or above* the metacarpophalangeal joint.

**The words "at or above" in the standard refers to the loss being closer to the body.*

c) *Amputation of foot*

When a member loses a foot, or a member loses all toes on the same foot (including big toe), the member is eligible for a TSGLI benefit for amputation of foot if the member meets the following standard:

If the member suffers…	OR the member suffers…
Amputation of foot at or above* the ankle	Amputation of all toes (including the big toe) on the same foot at or above* the metatarsophalangeal joint.

**The words "at or above" in the standard refers to the loss being closer to the body.*

d) *Amputation of toes*

When a member loses four toes on the same foot or the member loses one big toe, the member is eligible for a TSGLI benefit for amputation of toes if the member meets the following standard:

If the member suffers…	OR the member suffers…
Amputation of four toes (not including the big toe) on one foot at or above* the metatarsophalangeal joint	Amputation of big toe at or above* the metatarsophalangeal joint.

**The words "at or above" in the standard refers to the loss being closer to the body.*

5) Limb Salvage

When a member opts to save a limb rather than have the limb amputated, the member is eligible for a TSGLI benefit for limb salvage if the member meets the following standard:

If the member undergoes…	AND a surgeon certifies that…
A series of operations designed to avoid amputation of an arm or a leg while at the same time maximizing the limb's functionality. The surgeries typically involve bone and skin grafts, bone resection, reconstructive, and plastic surgeries and often occur over a period of months or years. Note: A complex leg or arm fracture does not automatically qualify as limb salvage. Limb salvage is based upon both the nature of the surgeries involved and whether the member's limb was medically at risk of amputation.	the patient is undergoing limb salvage surgery as defined in the column to the left.

6) Facial Reconstruction

When a member suffers a severe maxillofacial injury, the member is eligible for a TSGLI benefit for facial reconstruction if the member meets the following standard:

If the member undergoes…	AND a surgeon certifies that…
surgery to correct traumatic avulsions (i.e. separation, detachment or tear) of the face or jaw that cause discontinuity defects. Note: In order to meet the standard for facial reconstruction, the member must experience a penetrating facial injury (avulsion) and lose bone or tissue that without replacement would leave a "gap" in the area of injury (discontinuity defect).	the surgery was to correct discontinuity loss to one or more of the following facial areas: the upper or lower jaw, 50% or more of the cartilaginous nose, 50% or more of the upper or lower lip, 30% or more of the left or right periorbita, 50% or more of any of the following facial subunits: • forehead, • left or right temple, • left or right zygomatic, • left or right mandibular, • left or right infraorbital • chin

7) Activities of Daily Living (ADL)

Activities of Daily Living (ADL) are routine self-care activities that a person normally performs every day without needing assistance. There are six basic ADL: eating, bathing, dressing, toileting, transferring (moving in and out of bed or chair) and continence (managing or controlling bladder and bowel functions). The following aspects of ADL loss are covered in this section:

a) Determining if a member has loss of ADL

b) Coma due to Traumatic Brain Injury (TBI)

c) Loss of ADL due to TBI

d) Coma combined with loss of ADL due to TBI

e) Coma due to TBI combined with another injury

f) Loss of ADL due to TBI combined with another injury

g) Loss of ADL due to traumatic injury (other than traumatic brain injury)

h) Break between consecutive periods of inability to perform ADL

i) Loss of ADL due to another injury that qualifies for payment

a) Determining if a member has a loss of ADL

A member is considered to have a loss of ADL if the member **REQUIRES assistance** to perform at least two of the six activities of daily living. If the patient is able to perform the activity by using accommodating equipment (such as a cane, walker, commode, etc.) or adaptive behavior, the patient is considered able to independently perform the activity.

REQUIRES assistance is defined as:

- Physical assistance - when a patient requires hands-on assistance from another person

- Stand-by assistance - when a patient requires someone to be within arm's reach because the patient's ability fluctuates and physical or verbal assistance may be needed

- Verbal assistance - when a patient requires verbal instruction in order to complete the ADL due to cognitive impairment. Without these verbal reminders, the patient would not remember to perform the ADL.

Without this physical, stand-by, or verbal assistance, the patient would be incapable of performing the task.

Note: If member was approved for Special Compensation for Assistance with Activities of Daily Living (SCAADL) this does not guarantee eligibility for a TSGLI benefit. The eligibility criteria for SCAADL is not the same as the ADL loss standard under the TSGLI program.

The table below should be used to help to determine whether a member has lost the ability to perform a particular ADL.

Patient is…	**if he/she requires physical, stand-by, or verbal assistance from another person…**
UNABLE to bathe independently	to bathe more than one part of the body (via tub bath or sponge bath) or get in or out of the tub or shower
UNABLE to maintain continence independently	to manage catheter or colostomy bag. The patient is also unable to maintain continence independently if he/she is partially or totally unable to control bowel and bladder function.
UNABLE to dress independently	to get and put on appropriate clothing (i.e. dress for the correct season), socks or shoes (may have help tying shoes).
UNABLE to eat independently	to get food from plate to mouth, or take liquid nourishment from a straw or cup. The patient is also unable to eat independently if he/she is fed intravenously or by a feeding tube.
UNABLE to toilet independently	to go to and from the toilet, get on and off the toilet, clean self after toileting, or get clothing off and on before and after toileting. The patient is also unable to toilet independently if he/she must use a bedpan or urinal.
UNABLE to transfer independently	to move into or out of a bed or chair.

b) Coma due to Traumatic Brain Injury (TBI)

When a member is in a coma due to a traumatic injury, TSGLI benefits will be paid based on the number of consecutive days the member is in a coma.

The duration of the coma includes the date the coma began and the date the member recovered from the coma.

Benefits Schedule - Payments for coma due to TBI will be made as follows:

- $25,000 at the 15th consecutive day
- An additional $25,000 at the 30th consecutive day
- An additional $25,000 at the 60th consecutive day
- An additional $25,000 at the 90th consecutive day

Example 1: On May 1, a member goes into a coma as the result of a military motor vehicle accident. The member recovers from the coma 60 days later on June 29. The member's TSGLI benefit will be $75,000 for the 60 consecutive days in a coma.

Note: The member's first day in a coma must occur within 730 days of the traumatic event in order to receive payment. If subsequent days in a coma occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days in a coma that began before the end of the 730-day period. As soon as the member comes out of a coma, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2013, a member is hit by an IED. He is treated for a range of shrapnel wounds and TBI throughout the next two years. However, a piece of shrapnel that remained lodged in the member's brain from the IED moves causing bleeding and swelling. On December 26, 2014, the member goes into a coma from the bleeding and swelling. The member remains in a coma until January 17, 2015. The member's TSGLI benefit will be $25,000 for 15 consecutive days in a coma.

c) Loss of ADL due to TBI

When a member is unable to perform at least two of the six activities of daily living (ADL) due to TBI, TSGLI benefits will be paid based on the number of consecutive days the member has loss of ADL due to the brain injury.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefits Schedule - Payments for loss of ADL due to TBI will be made as follows:

- $25,000 at the 15th consecutive day
- An additional $25,000 at the 30th consecutive day
- An additional $25,000 at the 60th consecutive day
- An additional $25,000 at the 90th consecutive day

Example 1: On May 1 a member suffers TBI due to a helicopter accident. As a result, the member is unable to dress and transfer without assistance from May 1 through May 30. The member's TSGLI benefit will be $50,000. The $50,000 benefit for inability to perform two ADL includes $25,000 for 15 consecutive days and an additional $25,000 for 30 consecutive days.

Note: The member's first day of ADL loss due to TBI must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of ADL loss due to TBI occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of ADL loss that began before the end of the 730-day period. As soon as the member regains ADL function, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2013, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 28, 2014, the member's TBI worsens to the point of losing his ability to perform the ADL of bathing and dressing. The member regains his ability to perform the ADL of bathing and dressing on February 15, 2015. The member's TSGLI benefit will be $50,000 for the loss of two ADL for 30 consecutive days. If the member should again lose the ability to perform two ADL after the break in consecutive days of ADL loss on February 15, 2015, he cannot be paid an additional benefit.

d) Coma combined with loss of ADL due to TBI

When a member is in a coma due to TBI, TSGLI benefits will be paid based on the number of consecutive days the member is in a coma. If the member also has loss of ADL due to TBI, the time in a coma and the loss of ADL due to TBI must be analyzed as one continuous time period, not two separate time periods.

Note: Loss of ADL due to TBI will only be considered after the member comes out of the coma, and will be paid on the same benefit schedule.

Benefits Schedule - Payments for coma and loss of ADL from TBI will be made as follows:

- $25,000 at the 15th consecutive day
- An additional $25,000 at the 30th consecutive day
- An additional $25,000 at the 60th consecutive day
- An additional $25,000 at the 90th consecutive day

Example: On May 1, a member goes into a coma as the result of a military motor vehicle accident. The member recovers from the coma 30 days later on May 31. However, the member remains unable to independently perform two of six activities of daily living due to TBI for an additional 30 days, until July 1. The member's TSGLI benefit will be $75,000. The payment consists of $50,000 for the 30 consecutive days in a coma, and $25,000 for the additional 30 consecutive days of inability to independently perform two of six ADL due to TBI.

e) Coma due to TBI combined with another injury

When a member suffers a coma in combination with another injury, the member's TSGLI benefit will include the benefit for the number of consecutive days the member is in a coma plus the benefit for the other injury up to a combined maximum payment of $100,000.

The duration of the coma includes the date the coma began and the date the member recovered from the coma.

Benefits Schedule - Payments for coma will be made as follows:

- $25,000 at the 15th consecutive day
- An additional $25,000 at the 30th consecutive day
- An additional $25,000 at the 60th consecutive day
- An additional $25,000 at the 90th consecutive day

Example: On May 1, a member goes into a coma as the result of an automobile accident. The member recovers from the coma 77 days later on July 16, and his doctor finds he has suffered total and permanent loss of speech. The member submits a TSGLI claim on August 1. The benefit paid to the member will be $50,000 for the loss of speech plus $50,000 for 30 days in a coma*, for a total of $100,000. The $50,000 benefit for the coma includes $25,000 for 15 consecutive days and an additional $25,000 for 30 consecutive days.

*Note: Even though the member's coma extended through 60 days, an additional payment of $25,000 will not be made because the combined payment cannot exceed the $100,000 maximum.

f) Loss of ADL due to TBI combined with another injury

When a member is unable to perform two of the six activities of daily living (ADL) due to TBI in combination with another injury, the member's TSGLI benefit will include the benefit for the number of consecutive days the member has loss of ADL due to the brain injury plus the benefit for the other injury up to a combined maximum payment of $100,000.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefits Schedule - Payments for loss of ADL due to traumatic brain injury will be made as follows:

- $25,000 at the 15th consecutive day
- An additional $25,000 at the 30th consecutive day
- An additional $25,000 at the 60th consecutive day
- An additional $25,000 at the 90th consecutive day

Example: A member suffers traumatic brain injury and permanently loses sight in one eye as the result of a helicopter accident. Beginning May 1, the member is unable to eat, transfer or toilet without assistance. Fifteen days later on May 15, the member regains the ability to eat, transfer and toilet. The member's TSGLI benefit will be $50,000 for the loss of sight in one eye plus $25,000 for 15 consecutive days of lost ADL due to brain injury, for a total of $75,000.

g) Loss of ADL Due to Traumatic Injury Other Than TBI (OTI)

When a member is unable to perform two of the six activities of daily living (ADL) due to a traumatic injury other than TBI, the TSGLI benefit will be paid based on the number of consecutive days the member is unable to perform ADL.

The duration of the loss of ADL includes the date the member began to be unable to perform ADL and the date the member was again able to perform ADL.

Benefit Schedule - Payments for loss of ADL due to traumatic injury other than brain injury (OTI) will be made as follows:

- $25,000 at the 30th consecutive day
- an additional $25,000 at the 60th consecutive day
- an additional $25,000 at the 90th consecutive day
- an additional $25,000 at the 120th consecutive day

Example 1: A member sustains shrapnel wounds to the pelvis and is unable to get out of the bed (transferring) and unable to go to and from the bathroom (toileting) for 31 days from May 1 through May 31. The member's TSGLI benefit will be $25,000 for the 30 days of loss of ADL.

Note: The member's first day of ADL loss due to OTI must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of ADL loss due to OTI continue after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of ADL loss that began before the end of the 730-day period. As soon as the member regains ADL function, the consecutive day period ends and no further benefits can be paid.

Example 2: On January 1, 2013, a member falls down a cliff while hiking and injures both legs. Almost two years later on December 29, 2014, a pyogenic infection in both legs related to the fall causes the member to lose the ability to perform the ADL of bathing, transferring and dressing. The member regains his ability to perform the ADL of bathing and dressing on January 30, 2015. The member's TSGLI benefit will be $25,000 for the loss of two ADL for 30 consecutive days. If the member should again lose the ability to perform two ADL after the break in consecutive days of ADL loss on January 30, 2015, he cannot be paid an additional benefit.

h) Break Between Consecutive Periods of Loss of ADL

If a member has a loss of ADL for a scheduled number of consecutive days, then regains the ability to perform ADL, the member must have a loss of ADL for the full length of the next scheduled payment interval in order to be eligible for another TSGLI payment. The member must sustain the loss of at least two of the six ADL for the entire period of days. The table and example below illustrate this situation.

If the member has a loss of ADL for…	**then regains the ability to perform ADL…**	**The member must have a loss of ADL for another…**	**to receive the next TSGLI benefit payment.**
30 consecutive days		60 consecutive days	
60 consecutive days		90 consecutive days	
90 consecutive days		120 consecutive days	

Example: A member is hospitalized with shrapnel wounds on January 1 and is unable to dress or bathe for 30 consecutive days. The member receives a benefit of $25,000 for the 30-day loss of ADL. The member is released from the hospital on January 31. On March 1, the member has additional surgery and treatment for the shrapnel wounds and is again unable to bathe and dress.

In order to receive an additional payment for this second loss of ADL, the member must be unable to bathe and dress for 60 consecutive days from March 1.

i) Loss of ADL due to another injury that qualifies for payment

When a member has a loss of ADL due to another injury that qualifies for payment, the certifying official must compare the scheduled payment for the injury to the scheduled payment for the loss of ADL. In some cases the member would receive a greater amount for loss of ADL than for a single injury. The table below illustrates this situation.

The member…	**with a scheduled payment of…**	**The member also has loss of ADL for…**	**with a scheduled payment of…**	**The member's benefit will be…**
Loses a foot	$50,000	30 consecutive days	$25,000*	$50,000 for the loss of foot

The member…	with a scheduled payment of…	The member also has loss of ADL for…	with a scheduled payment of…	The member's benefit will be…
Loses a foot	$50,000	60 consecutive days	$50,000*	$50,000 for either the loss of foot or 60-day ADL loss
Loses a foot	$50,000	90 consecutive days	$75,000 *	$75,000 for the 90-day loss of ADL

**The scheduled payment represents the total of the $25,000 benefit payments made at 30-day intervals.*

8) Inpatient Hospitalization

A member who is hospitalized as an inpatient for 15 consecutive days as the result of a traumatic injury is eligible for a $25,000 payment under TSGLI. The following general rules apply to the inpatient hospitalization benefit.

a) Inpatient hospitalization days include transportation time from the site of the injury to the hospital, transfers from one hospital to another, the day of admission and the day of release.

b) Payment for a 15-day inpatient hospital stay replaces the first ADL milestone payment only and can only be issued once per qualifying traumatic event. Subsequent periods of 15-day inpatient hospitalization due to the same traumatic injury do not qualify for an additional benefit.

c) Combinations of inpatient hospitalization and ADL loss must be continuous (occur on consecutive days) to qualify for the second ADL milestone payment.

d) Inpatient hospitalization for fewer than 15 days and inpatient hospitalization for non-consecutive days is not eligible for the TSGLI benefit.

e) Inpatient hospitalization for coma/TBI may be combined with other injuries provided the inpatient hospitalization is primarily due to TBI or coma.

f) Inpatient hospitalization for traumatic injuries other than coma/TBI may not be combined with other injuries.

g) Inpatient hospitalization for illnesses and diseases is not covered under TSGLI (except for disease caused by a pyogenic infection, biological, chemical, or radiological weapon, or accidental ingestion of a contaminated substance.)

The Inpatient Hospitalization benefit provides the opportunity for a member to receive a TSGLI benefit even if the loss of ADL are for less than 30 consecutive days.

Definition of a Hospital – an *inpatient facility* is 1) accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); 2) used primarily to provide, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; 3) requires every patient to be under the care and supervision of a physician; and 4) provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered nurse on duty at all times; or any Armed Forces medical facility that is authorized to provide inpatient and/or ambulatory care to eligible Service members This includes Combat Support Hospitals, Air Force Theater Hospitals and Navy Hospital Ships.

Note 1: Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, nursing care or for the aged; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is for residential or domiciliary living; or (4) is mainly a school.

Note 2: The following VA Medical Center treatment programs are included in the inpatient hospitalization definition: Polytrauma Transitional Rehabilitation Programs (PTRP) and Post-Deployment Rehabilitation and Evaluation Programs (PREP). The VA Medical Center Service member Transitional Advanced Rehabilitation Programs (STAR) does not meet the definition of inpatient hospitalization. Other programs at medical centers need to be evaluated based on the standards in the definition of inpatient hospitalization.

a) *Inpatient Hospitalization Days*

The count of consecutive inpatient hospitalization days begins when the injured member is transported from the site of the injury to the hospital, includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of release.

Example 1: A member is injured in Iraq on March 1. The member is stabilized in the field, then medevac'd to Landstuhl on the same day. The member spends 4 days in Landstuhl being further stabilized, and is flown to WRAMC on March 4. The member is released from WRAMC to Mologne House on March 15. The member has accrued 15 consecutive hospitalization days (March 1 – 15) and is paid a $25,000 TSGLI benefit.

Example 2: A member is injured in an automobile accident on March 1. The member is taken to a local hospital trauma center and is admitted to the hospital. On March 6, the member's condition is stabilized and the member is transferred to another hospital. The member is released from the second hospital on March 17. The member has accrued 15 consecutive hospitalization days (March 1-15) and is paid a $25,000 TSGLI benefit.

Note: The member's first day of inpatient hospitalization must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of hospitalization continue after the 730-day period ends, the member can still be paid a benefit, as long as the 15 days of inpatient hospitalization that began before the end of the 730-day period are consecutive.

Example 3: On January 1, 2013, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 30, 2014, the member is hospitalized at the Tampa VAMC for TBI treatment. The member remains in the hospital through January 17, 2015. The member's TSGLI benefit will be $25,000 for 15 consecutive days of inpatient hospitalization.

b) Payment for a 15-day inpatient hospital stay replaces the first ADL milestone payment.

If a member is hospitalized as an inpatient for 15 consecutive days, the member's hospitalization takes the place of the first ADL milestone payment only. Fifteen days of inpatient hospitalization cannot be substituted for any other ADL milestone payment. Payment will be made for the 15-day inpatient hospitalization OR the first ADL milestone, whichever occurs first. Once a payment has been made for 15-day inpatient hospitalization, there are no additional payments for subsequent 15-day inpatient hospital stays due to the same traumatic injury.

There are two situations covered by this replacement.

- Member is hospitalized due to coma/Traumatic Brain Injury (TBI)
- Member is hospitalized due to other traumatic injury

Member is hospitalized due to coma/TBI - When a member is hospitalized as an inpatient for 15 consecutive days and the hospitalization is primarily due to Coma/TBI, payment for hospitalization replaces the 15-day Coma/TBI ADL milestone.

Member is hospitalized due to other traumatic injury - When a member is hospitalized as an inpatient for 15 consecutive days and the hospitalization is due to a traumatic injury other than Coma/TBI, payment for inpatient hospitalization replaces the 30-day other traumatic injury ADL milestone.

The chart below illustrates these replacements.

		For **Coma/TBI**	For Other traumatic injury
15- day inpatient hospitalization replaces first ADL milestone only	**ADL milestone 1**	15 days	30 days
	ADL milestone 2	30 days	60 days
	ADL milestone 3	60 days	90 days
	ADL milestone 4	90 days	120 days

Example 1: A member is injured in a car accident on March 1. He is hospitalized from March 1 to March 12 but due to his injuries he is unable to perform the ADL of bathing and dressing for 30 days from March 1 to March 30. He regains his ADL on March 31. However, due to complications, he is hospitalized a month later from May 1 to May 15. The member will receive a $25,000 benefit for loss of ADL due to OTI for 30 days. He will not be paid for the subsequent 15-day hospitalization. Payment is made for either the 15-day hospitalization OR the first ADL milestone, whichever occurs first, not both.

Example 2: A member is injured in an accident on a construction site on July 1 resulting in major abdominal injuries. The member is taken to a local hospital trauma center and is admitted to the hospital. Due to the severity of her injuries, she is hospitalized for two months. She is released from the hospital on September 4. The member is eligible for a $25,000 payment for a 15-day inpatient hospitalization. The member will not be paid any additional benefit for the additional 45 days in the hospital, unless there is continuous ADL loss – see (c) below as the 15-day inpatient hospitalization benefit is a one-time benefit paid for the first 15-days of hospitalization only.

c) Combinations of inpatient hospitalization and ADL loss must be continuous (occur on consecutive days) to qualify for the second ADL milestone payment

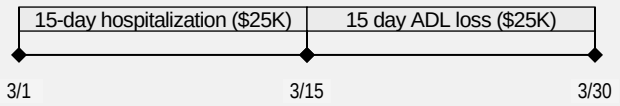
If a member is hospitalized as an inpatient for 15 consecutive days the member's hospitalization takes the place of the first ADL milestone payment only. If the member is also unable to perform two ADL during and/or after 15 days of inpatient hospitalization, the member's ADL loss must continue through or immediately follow the first ADL milestone to qualify for the second ADL milestone payment. In other words, the ADL loss must follow on consecutive days after the 15-day inpatient hospitalization period ends.

There are two situations covered by this rule.

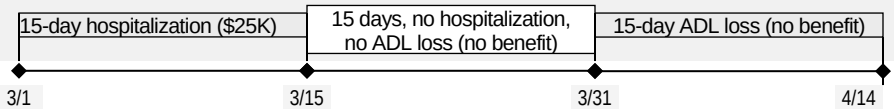
- Member is hospitalized due to coma/Traumatic Brain Injury (TBI) and has subsequent ADL loss
- Member is hospitalized due to other traumatic injury and has subsequent ADL loss
-

Member is hospitalized as an inpatient due to coma/(TBI) and has subsequent ADL loss - When a member is hospitalized as an inpatient for 15 days due to coma/TBI, the member's hospitalization replaces the first 15-day ADL milestone. If the member suffers 15 days of ADL loss that begins or continues after inpatient hospitalization, the member's ADL loss must continue through or immediately follow the 15th day of inpatient hospitalization to qualify for the second ADL milestone payment.

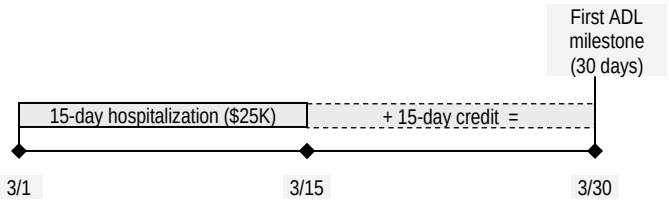
Example 1: A member is injured in a construction accident on March 1, suffers TBI and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through March 31, the member is unable to eat, dress and transfer without assistance due to TBI. The member will receive a $50,000 TSGLI benefit, $25,000 for 15-day inpatient hospitalization (which counts as the first ADL milestone), and $25,000 for 15 days of inability to perform ADL (the second ADL milestone)



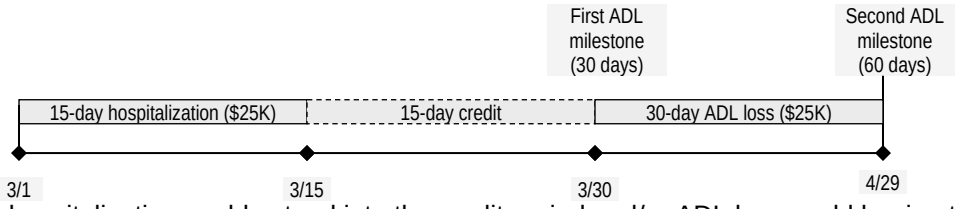
Example 2: A member is in an automobile accident on March 1, suffers a head injury resulting in TBI and is admitted to the hospital. The member is released from the hospital on March 15 and is able to perform ADL. On March 31, the member's condition worsens and the member needs assistance bathing and toileting. This assistance is needed until April 14. The member will receive a $25,000 TSGLI benefit for the 15-day inpatient hospital stay (which counts as the first ADL milestone). The member cannot receive payment for the loss of ADL because the member's loss of ADL did not immediately follow the 15-day inpatient hospitalization period. There was a break in the continuous days requirement for qualifying for the next ADL milestone.



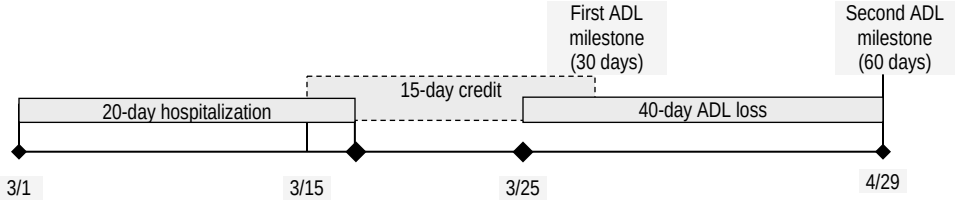
Member is hospitalized as an inpatient due to other traumatic injury and has subsequent ADL loss - When a member is hospitalized as an inpatient for 15 days due to a traumatic injury other than coma/TBI, the member's 15-day inpatient hospitalization replaces the first 30-day ADL milestone. In other words, if the member is hospitalized as an inpatient for 15 days, they are deemed to have reached the first 30-day ADL milestone. In effect, this means the member receives a 15-day "credit" to complete the first 30-day milestone period.



If the member suffers ADL loss after 15 days of inpatient hospitalization, the member's ADL loss must continue for 30 days from the end of the first 30-day milestone to qualify for the second ADL milestone payment.

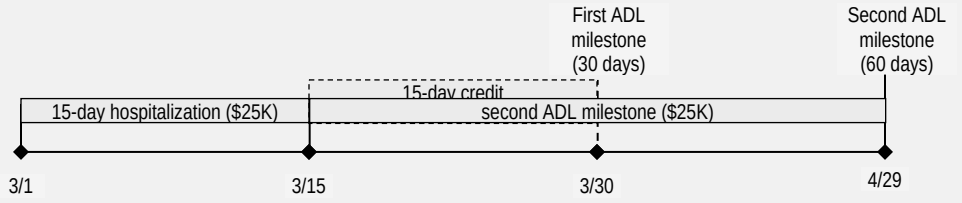


Inpatient hospitalization could extend into the credit period and/or ADL loss could begin at any time during the credit period, but this will not affect the requirement of continuous ADL loss for 30 days from the end of the first ADL milestone to receive the second ADL milestone payment.

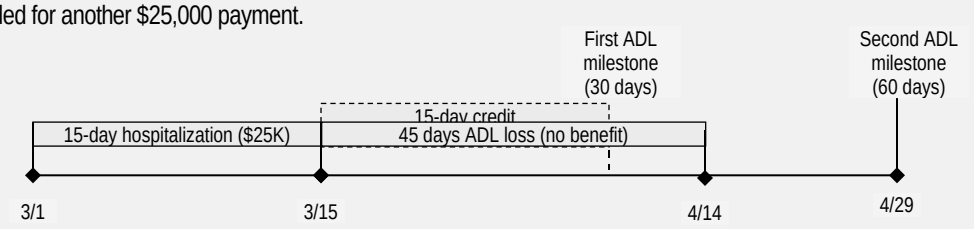


The examples below illustrate how inpatient hospitalization combined with ADL loss is applied.

Example 1: A member is injured in an IED blast on March 1, suffers injuries to arms and torso and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through April 29, the member is unable to eat, dress and transfer without assistance. The member will receive a $50,000 TSGLI benefit, $25,000 for 15-day inpatient hospitalization, (March 1 – March 15) which deems the member to have reached the first ADL milestone period at March 30, and $25,000 for continuous ADL loss for 30 days from the end of the first ADL milestone (March 30 – April 29), reaching the second ADL milestone period.



Example 2: A member is in an automobile accident on March 1, suffers a leg injury and is admitted to the hospital. The member is released from the hospital on March 15. From March 1 through April 14, 45 days, the member is unable to dress and transfer without assistance. The member will receive a $25,000 TSGLI benefit for the 15-day inpatient hospital stay, (March 1 – March 15) which deems the member to have reached the first ADL milestone period at March 30th. The member cannot receive an additional payment for the loss of ADL that occurred after the hospitalization because the member's loss of ADL, while 45 days in length, did not continue until April 29th, the 60- day milestone, needed for another $25,000 payment.



Note: The member's first day of inpatient hospitalization must occur within 730 days of the traumatic event in order to receive payment. If subsequent days of hospitalization, immediately followed by consecutive days of the loss of ability to perform two ADLs, occur after the 730-day period ends, the member can still be paid a benefit, up to the maximum number of consecutive days of inpatient hospitalization and ADL loss that began before the end of the 730-day period.

Example 1: On January 1, 2013, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 25, 2014, the member is hospitalized at the Tampa VAMC for TBI treatment. The member remains in the hospital through January 17, 2015. From January 17, 2015 through February 28, 2015 the member is unable to perform the ADLs of bathing, dressing and toileting without verbal assistance. The member's TSGLI benefit will be $75,000 for loss of two ADL for 60 days due to TBI, which includes payment for 15 consecutive days of hospitalization as the first ADL milestone.

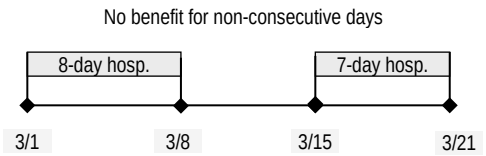
Example 2: On January 1, 2013, a member is hit by an IED and suffers a TBI. After initial improvements in his condition, almost two years later on December 25, 2014, the member is hospitalized at the Tampa VAMC for TBI treatment. The member remains in the hospital through January 17, 2015. From January 17, 2015 through February

28, 2015 the member is unable to perform the ADLs of bathing, dressing and toileting without verbal assistance. On April 15, 2015, the member is again unable to perform the ADLs of bathing, dressing and toileting without verbal assistance and does not regain that ability until August 1, 2015. The member's TSGLI benefit will be $75,000 for loss of the ability to perform two ADL for 60 days due to TBI beginning on December 25, 2014. This includes payment for 15 consecutive days of hospitalization as the first ADL milestone. The member cannot be paid for the loss of the ability to perform two ADL that began on April 15, 2015 as there was a break, which means the first day of ADL for the new period began after the 730-day limit.

d) Inpatient hospitalization for fewer than 15 days and hospitalization for non-consecutive days is not eligible for the TSGLI benefit.

If a member is hospitalized as an inpatient for less than 15 days, or for non-consecutive periods, the member is not eligible for the TSGLI benefit for hospitalization.

Example: A member is injured in a construction accident on March 1 and is admitted to the hospital. The member is released from the hospital on March 8 (8 days). The member then develops complications from his injury and is admitted to the hospital on March 15. The member is released from the hospital on March 21 (7 days). Even though the member was hospitalized as an inpatient for a total of 15 days, the member is not eligible for the TSGLI benefit because the days were not consecutive.



e) Inpatient hospitalization for coma/TBI may be combined with other injuries provided inpatient hospitalization is primarily due to TBI or coma.

If a member is hospitalized as an inpatient for 15 consecutive days due to TBI or coma and the member has another injury that is listed on the schedule of losses, the member's TSGLI benefit will include the benefit for the 15-day inpatient hospitalization plus the benefit for the other injury (up to $100,000). In order to combine the two benefits, the member's hospitalization must be due to coma or TBI.

Example: On March 1, a member suffers TBI and permanently loses sight in one eye as the result of a helicopter accident. The member is admitted to the hospital on March 1 and the member remains in the hospital to treat swelling of the brain. The member is released on March 17 (17 days). Since the member's inpatient hospitalization was due to TBI, the member's TSGLI benefit will be $50,000 for the loss of sight in one eye plus $25,000 for 15 consecutive days of hospitalization due to TBI, for a total of $75,000.

Example 2: A member is in an automobile accident on March 1, suffers a head injury and loss of one hand, and is admitted to the hospital in a coma. The member recovers from the coma on March 19, but remains in the hospital until March 30 due to amputation of his hand. Since the member had a 15-day inpatient hospitalization due to coma, the member's TSGLI benefit will be $50,000 for the loss of one hand plus $25,000 for 15 consecutive days of hospitalization due to coma, for a total of $75,000.

f) Inpatient hospitalization for traumatic injuries other than coma/TBI may be not combined with other injuries.

If a member is hospitalized as an inpatient for 15 consecutive days due to a traumatic injury other than coma/TBI and the member has another injury, the member's TSGLI benefit will be for the highest paying injury.

Example 3: A member is in a vehicle that is hit by an IED on March 1. The member suffers injuries to his leg and has mild TBI. The member is admitted to the hospital on March 1 and his leg is amputated. The member remains in the hospital for further treatment of wounds associated with his leg injury and is released from the hospital on March 18. Since inpatient hospitalization due to "other traumatic injuries" cannot be combined with other injuries as a single loss, the members TSGLI benefit will be $50,000 for the loss of one leg because it is the higher paying of the two injuries.

g) Inpatient hospitalization for illnesses and diseases is not covered under TSGLI. (except for illness or disease caused by a pyogenic infection, biological, chemical, or radiological weapon, or accidental ingestion of a contaminated substance.)

Illnesses and diseases are not considered traumatic injuries under TSGLI and, therefore inpatient hospitalization resulting from either, does not provide a TSGLI benefit.

Example 1: A member is involved in a roadside bomb explosion on April 1. The member is injured by shrapnel from the bomb but suffers no qualifying TSGLI losses at that time. A year and a half later the member is suffering from PTSD due to what he witnessed from the explosion. He is admitted as an inpatient for 30 days to a hospital to address his acute PTSD symptoms. The member is not entitled to a TSGLI benefit.

h) Inpatient hospitalization when TBI and PTSD may both be present

In some cases, medical professionals are not able to determine whether a member is suffering from TBI or PTSD (or both), as they can present similarly. The member may be hospitalized undergoing diagnostic assessment to determine which condition is present. In such cases, utilize the following chart to determine if the member's hospitalization would result in a payable loss.

If the member is hospitalized for 15 consecutive days to undergo a diagnostic assessment for…	And the assessment determines that…	The loss is…
PTSD	The member has PTSD and not TBI	Not payable as losses due to illnesses/diseases are excluded from payment.
PTSD	The member has TBI	Payable for $25,000
PTSD	The member has TBI and PTSD	Payable for $25,000
TBI	The member has PTSD and not TBI	Payable for $25,000
TBI	The member has TBI	Payable for $25,000
TBI	The member has TBI and PTSD	Payable for $25,000

9) Genitourinary Losses

When a member suffers anatomical loss of the penis, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	**OR the member suffers…**
Amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body),	Damage to the glans penis or shaft of the penis that requires reconstructive surgery

When a member suffers permanent loss of use of the penis, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	**OR the member suffers…**
Damage to the glans penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member	Damage to the shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member

When a member suffers anatomical loss of one or both testicle(s), the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	OR the member suffers…	OR the member suffers…
Amputation of, or damage to one or both testicle(s) that requires testicular salvage	Amputation of, or damage to one or both testicle(s) that requires reconstructive surgery	Amputation of, or damage to one or both testicle(s) that requires reconstructive surgery and testicular salvage

When a member suffers permanent loss of use of both testicles, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…
Damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member
NOTE: Based on medical advice, TSGLI benefits are not payable for loss of use of one testicle, as remaining testicle will compensate for damaged testicle.

When a member suffers anatomical loss of the vulva, uterus or vaginal canal, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	OR the member suffers…
Complete or partial amputation of the vulva, uterus, or vaginal canal	Damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery

When a member suffers permanent loss of use of the vulva or vaginal canal, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…
Damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

When a member suffers anatomical loss of one or both ovaries, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	OR the member suffers…	OR the member suffers…
Amputation of, or damage to one or both ovaries that requires ovarian salvage	Amputation of, or damage to one or both ovaries that requires reconstructive surgery	Amputation of, or damage to one or both ovaries that requires reconstructive surgery and ovarian salvage

When a member suffers permanent loss of use of both ovaries, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…
Damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member
NOTE: Based on medical advice, TSGLI benefits are not payable for loss of use of one ovary, as remaining ovary will compensate for damaged ovary.

When a member suffers total and permanent loss of urinary system function, the member is eligible for a TSGLI benefit if the member meets the following standard:

If the member suffers…	That requires…
Damage to the urethra, ureter(s), both	• Urinary Diversion

If the member suffers…	That requires…
kidneys, bladder or urethral sphincter muscle(s)	• Hemodialysis • Or Both
…which is reasonably certain to continue throughout the lifetime of the member.	

Part 5 – Filing a Claim for TSGLI

General Information

The member must use SGLV 8600, Application for TSGLI Benefits, to apply for TSGLI benefits. The application is available from the branch of service or the Department of Veteran's Affairs Insurance website at **www.benefits.va.gov/insurance**. The member (or guardian or power of attorney or military trustee) and a medical professional must complete the application.

The TSGLI application has 16 pages and is divided into two parts:

- Part A, Member's Claim Information and Medical Authorization
- Part B, Medical Professional's Statement.

Social Security Number

A space for the member's Social Security number is provided on pages 4 through 13 of the application. The member, guardian, power of attorney or military trustee must fill in the Social Security Number on each of these pages.

Completing Part A, Member's Claim Information & Medical Authorization

Part A of the application provides information about the Service Member's claim and his legal representative (if applicable). It also provides payment information and authorizes the service branch and OSGLI to request information about the Service Member.

Part A must be completed by: The Service Member, the appointed guardian, the power of attorney or the military trustee. Part A is divided into 7 sections:

1. Service Member Information
2. Guardian or Power of Attorney or Military Trustee Information
3. Traumatic Injury Information
4. Payment Options
5. Financial Counseling Request
6. Signature
7. Authorization for Release of Information

Section 1 – Service Member Information

The Service Member Information Section provides identifying information for the Service Member who is requesting TSGLI benefits. This section must be completed.

Section 2 – Guardian or Power of Attorney or Military Trustee Information

The Guardian or Power of Attorney or Military Trustee Section provides information about the Service Member's legal representative. This section is **only** completed the when the Service Member is not receiving payment or if the Service Member is incapable of signing the application. If this section is completed, the guardian, power of attorney or military trustee must include one of the following 4 items:

- Letters of guardianship, or
- Letters of conservatorship, or
- Power of attorney
- Application for trusteeship (DoD Form 2827)

What is a Military Trustee? - A military trustee is a fiduciary appointment made by the Defense Finance and Accounting Service at the Department of Defense on behalf of incompetent Servicemembers. Previously, a military trustee had the legal authority to handle only the member's military pay and allowances. Due to a change in the regulation governing the TSGLI program, the military trustee now can access and choose how to disburse the member's TSGLI benefit payment. The military trustee must provide an annual accounting of any disbursements, including the TSGLI payment, to DFAS. The trustee would be able to gain access to the Alliance Account after providing written confirmation of his or her appointment by DFAS. The appointment would be verified by the trustee's submission of DoD Form 2827, titled "Application for Trusteeship".

Section 3– Traumatic Injury Information

The Traumatic Injury Information Section provides information about the Service Member's traumatic injury. It contains two sub sections.

Information About Your Loss - The member, guardian, power of attorney or military trustee should answer the questions listed here. If any of these questions are answered yes, the member's loss does not qualify for TSGLI payment.

Tell Us About Your Traumatic Injury – The member, guardian, power of attorney or military trustee should describe the injury and its cause, giving specific date, time and location information if possible.

Note to Certifier: This section should be compared with Part B to ensure that all possible scheduled losses described here are included in the medical professional's statement.

Section 4– Payment Options

The Payment Options Section provides information about how the TSGLI benefit should be paid. There are three methods of payment:

1. Lump Sum - Prudential's Alliance Account®* or
2. Electronic Funds Transfer (EFT) or
3. Lump Sum - Check

The guardian, power of attorney or military trustee can request either EFT or check. If a guardian, power of attorney or military trustee does not select a payment option, the TSGLI benefit will be paid by check.

Service Members can request either the Alliance Account or EFT. If the Servicemember does not indicate a payment type, the TSGLI benefit will be paid through an Alliance Account.

*An Alliance Account is an interest bearing draft account established in the beneficiary's(ies') name(s) with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.

The funds in an Alliance Account begin earning interest immediately and will continue to earn interest until all funds are withdrawn. Interest is accrued daily, compounded daily and credited every month. The interest rate may change and will vary over time subject to a minimum rate that will not change more than once every 90 days. You will be advised in advance of any change to the minimum interest rate via your quarterly Alliance Account statement or by calling Customer Support at (877) 255-4262.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

For more information about these payment options, see Part 7, Payment of TSGLI Benefits.

Section 5 – Financial Counseling

The Financial Counseling Section allows the TSGLI recipient to elect to receive free, VA-sponsored financial counseling.

Section 6 – Signature

The Signature Section provides the signature verifying the member's identifying information and payment option selection. It also provides an optional third party authorization. The Service Member, guardian, power of attorney or military trustee must sign section 5.

Optional Third Party Authorization – the member should fill in this section if he/she wants to authorize a third party to speak with OSGLI or the branch of service on his/her behalf.

Description of Authority to act on behalf of the member - If the guardian, power of attorney or military trustee completes this section, they must also indicate their authority to act on behalf of the member (e.g. guardian, conservator, etc.)

When a Claimant is Competent but Unable to Sign the Application for TSGLI Benefits

When a claimant is mentally competent, but unable to sign the Application for TSGLI Benefits, the claimant may instead sign by a mark ("X")--or verbally affirm the validity of the information provided in the form--if:

- The claimant is unable to provide his or her signature due to a physical injury or disability;
- The claimant is of sound mind; **AND**
- Two impartial witnesses observe the claimant's mark or verbal affirmation* and add their own signatures to the appropriate signature block on the form.

* If the claimant indicates his or her agreement by verbal affirmation, that information should be noted on the form by one of the two impartial witnesses to the claimant's act (e.g., "Member physically unable to sign or mark **but has verbally attested to the information on this form**.").

***Note**:* A signature by a notary public is not required to attest to the validity of the mark or verbal affirmation made by the claimant, nor to the signatures of the two impartial witnesses.

Impartial Witness - An impartial witness is defined as a person who will receive no direct or indirect financial benefit from the claimant's receipt of a TSGLI payment.

Examples of an impartial witness: a medical professional who has been providing medical care to the TSGLI claimant, administrative personnel at the medical treatment facility, or fellow Service Members

Individuals who would not be considered an impartial witness include the claimant's family members, such as parents, children, or spouse.

Section 7 – Authorization to Release Information

The Authorization to Release Information Section authorizes the release of the Service Member's medical and personal information to the branch of service and the Office of Servicemembers' Group Life Insurance (OSGLI). The Service Member, the guardian, power of attorney or the military trustee must sign this section. The TSGLI claim cannot be paid without this authorization.

Completing Part B, Medical Professional's Statement

Part B of the application provides medical information about the Service Member's losses, medical condition and inability to perform certain activities.

Part B must be completed by a medical professional. The medical professional must be a licensed practitioner of the healing arts acting within the scope of his/her practice. Part B is divided into 6 sections:

1. Patient Information
2. Qualifying Losses Suffered by Patient
3. Other Information
4. Medical Professional's Comments
5. Medical Professional's Information
6. Medical Professional's Signature

Section 1 - Patient Information

The patient information section provides the patient's name, the date of the patient's injuries and indicates whether the patient is competent to handle his/her own affairs. If the patient is deceased, the medical professional must insert the date, time and cause of death.

Section 2 - Qualifying Losses Suffered by Patient

The qualifying losses section lists the TSGLI qualifying losses, along with the definition of each loss. The medical professional must determine if the patient's loss meets the definition given. The medical professional should then:

- Check the box next to each loss the patient has experienced that meets the definition given
- Fill in any additional information requested.

Note: The patient's loss **MUST** meet the definition of loss given or it should not be checked on the application.

Detailed instructions for each loss are given below.

Inpatient Hospitalization

If the patient has been hospitalized as an inpatient for 15 consecutive days as a result of a traumatic injury, the medical professional should check the box for inpatient hospitalization.

The medical professional should give information about the longest period of consecutive days the patient was hospitalized as an inpatient.

> Example: A patient is injured in an automobile accident on March 1, and is hospitalized for 5 days to stabilize his injuries. On April 1, the patient is readmitted to the hospital for surgery associated with those same injuries. The patient develops complications and remains hospitalized until April 20. The medical professional should enter inpatient hospitalization information for the second period of hospitalization, as it was the longest number of consecutive days hospitalized.

The count of consecutive inpatient hospitalization days begins when the injured member is transported to the hospital from the site of injury (if applicable), includes the day of admission, continues through subsequent transfers from one hospital to another, and includes the day of release.

After determining the longest period of inpatient hospitalization, the medical professional should fill in:

- The predominant reason for the patient's inpatient hospitalization, TBI or another traumatic injury

- The date the patient was transported to the hospital (if applicable)
- The date the patient was admitted to the first hospital,
- The date the patient was released from the final hospital,
- The name and address of the hospital (or hospitals).

If the patient is still hospitalized as an inpatient, the medical professional should check the box indicating the patient is still hospitalized.

> Definition of a Hospital – an *inpatient facility* is 1) accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); 2) used primarily to provide, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; 3) requires every patient to be under the care and supervision of a physician; and 4) provides 24-hour nursing services rendered or supervised by a registered professional nurse and has a licensed practical nurse or registered nurse on duty at all times; or any Armed Forces medical facility that is authorized to provide inpatient and/or ambulatory care to eligible Service members This includes Combat Support Hospitals, Air Force Theater Hospitals and Navy Hospital Ships.
>
> Note 1: Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, nursing care or for the aged; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is for residential or domiciliary living; or (4) is mainly a school.
>
> Note 2: The following VA Medical Center treatment programs are included in the inpatient hospitalization definition: Polytrauma Transitional Rehabilitation Programs (PTRP) and Post-Deployment Rehabilitation and Evaluation Programs (PREP). The VA Medical Center Service Member Transitional Advanced Rehabilitation Programs (STAR) does not meet the definition of inpatient hospitalization. Other programs at medical centers need to be evaluated based on the standards in the definition of inpatient hospitalization.

Counting consecutive inpatient hospitalization days for TSGLI qualifying loss – When counting consecutive inpatient hospitalization days, any breaks in inpatient hospitalization days would cause the count of days to start over. For example, if the patient is released from the hospital to a nursing facility or to his/her home after 10 days in the hospital, the count of consecutive hospitalization days end on the day of release. If the patient is subsequently re-hospitalized, the count of hospitalization days would begin at one, and the patient would have to accrue 15 consecutive days of inpatient hospitalization from the date of admission to qualify for TSGLI payment.

Loss of Sight

If the patient's loss meets the definition of loss of sight in one or both eyes, the medical professional should check the box(es) for loss of sight in the left and/or right eye and fill in:

- The date loss of sight began in the left and/or right eye
- The best corrected visual acuity and field in the left and/or right eye

A member will be considered eligible for a TSGLI benefit for loss of sight if the loss meets one of the three standards below:

	The member's visual acuity in at least one eye is…	And their peripheral vision in at least one eye is…	And the loss of vision …
1.	20/200 or less (worse) with corrective lenses	N/A	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.

2. Greater (better) than 20/200 with corrective lenses	a visual field of 20 degrees or less	has lasted at least 120 days OR will not improve (with reasonable certainty) throughout member's life.
3. Non-existent due to complete loss of the eye (s)	N/A	N/A

Measurement of Visual Acuity and Peripheral Vision - The medical professional should use any acceptable standard for measuring visual acuity and peripheral vision.

Loss of Speech

If the patient's loss meets the definition of loss of speech, the medical professional should check the box for loss of speech and fill in the date loss of speech began.

A member will be considered eligible for a TSGLI benefit for loss of speech if:

The member suffers…	and the loss of speech will…
an organic loss of speech (lost the ability to express oneself, both by voice and whisper, through normal organs for speech). *	not improve (with reasonable certainty) throughout member's life.

*If a member uses an artificial appliance, such as a voice box, to simulate speech, he/she is still considered to have suffered an organic loss of speech and is eligible for a TSGLI benefit.

Evaluating Organic Loss of Speech - The medical professional should use the standards below when evaluating organic loss of speech.

Organic Loss of Speech	Will be measured by:
Lost the ability to express oneself, both by voice and whisper, through normal organs for speech.	Evaluating the following aspects of speech: 1. **Audibility** -- the ability to speak at a level sufficient to be hear; 2. **Intelligibility** -- the ability to articulate and to link the phonetic units of speech with sufficient accuracy to be understood; and 3. **Functional efficiency** -- the ability to produce and sustain a serviceably fast rate of speech output over a useful period of time. When at least *one* of these attributes is missing, overall speech function is not considered effective. Assessments of speech proficiency should be made by an otolaryngologist or a speech therapist whose evaluation should be based *both* on personally listening to the claimant's speech and on a history of the claimant's performance in everyday living. The findings should be sufficient to provide the physician with a clear picture of the individual's speech capacity. Such an analysis would cover the attributes of speech discussed above and would include a detailed description of the following points: 1. *The intensity of speech (audibility)* -- the conditions under which the individual can and cannot be heard (e.g., in quiet surroundings, noisy places, a moving automobile); the maximum distance at which individuals can be heard; whether their voices tend to become inaudible, and if so, after how long; 2. *The ability to articulate (intelligibility)* -- the frequency of any difficulties with pronunciation, the extent to which the individual is asked to repeat, and

Organic Loss of Speech	Will be measured by:
	3. *The rate of speech and the degree of ease with which the individual's speech flows (functional efficiency)* -- how long he or she is able to sustain consecutive speech; the number of words spoken without interruption or hesitancy; whether he or she appears fatigued, and if so, after how long.

Loss of Hearing

If the patient's loss meets the definition for loss of hearing in one or both ears, the medical professional should check the box(es) for loss of hearing in left and/or right ear and fill in:

- The date loss of hearing began in the left and/or right ear
- The average hearing acuity in the left and/or right ear measured without amplification device

A member will be considered eligible for a TSGLI benefit for loss of hearing if:

The member's average hearing threshold sensitivity for air conduction in at least one ear is…	and the loss of hearing will…
80 decibels	not improve (with reasonable certainty) throughout member's life.

Measuring Hearing Threshold Sensitivity - The medical professional should use the standard below when measuring hearing threshold sensitivity.

Hearing Threshold Sensitivity for Air Conduction	Will be measured by:
80 decibels	Utilizing pure-tone audiometry. A hearing threshold sensitivity measurement of 80 decibels should be reached by obtaining a pure-tone average (PTA). The PTA is the average of pure tone hearing thresholds at 500, 1000, and 2000 Hz. Examinations will be conducted without the use of hearing aids or other hearing amplification device.

Burns

If the patient's loss meets the definition for burns to the body or burns to the face, the medical professional should check the box(es) for burns to the body and/or face and fill in as appropriate:

- The percentage of the body (including face and head) affected by burns
- The percentage of the face affected by burns

When filling in the percentage of the face and body affected by burns, the medical professional should calculate the percentage of the entire body, including the face and head, affected by burns. If applicable, the medical professional should then make a separate calculation of the percentage of the face affected by burns. Percentage may be measured using the Rule of Nines or any other acceptable alternative.

A member will be considered eligible for a TSGLI benefit for burns if:

The member has …	OR The member has…
2nd degree (partial thickness) burns over 20% of the body including the face and head	2nd degree (partial thickness) burns over 20% of the face only

Note: Road Rash is not considered a burn, but rather a deep skin abrasion due to the scraping of skin on hard surfaces. Members suffering from road rash due to a traumatic event should not claim burns on their TSGLI application, but identify other losses covered under TSGLI for which they qualify.

Coma

If the patient has been in a coma due to brain injury for at least 15 consecutive days the medical professional should check the box for coma and fill in:

- The date of onset of the coma
- The date of recovery from the coma
- The patient's Glasgow coma score at the 15th, 30th, 60th and 90th day for each time period applicable

If the patient is still in a coma, the medical professional should check the box indicating that the coma is ongoing.

A member will be considered eligible for a TSGLI benefit for coma if:

The member is in a coma with…	**that lasts for…**
brain injury measured at a Glasgow Coma Score of 8 or less	at least 15 consecutive days

Facial Reconstruction

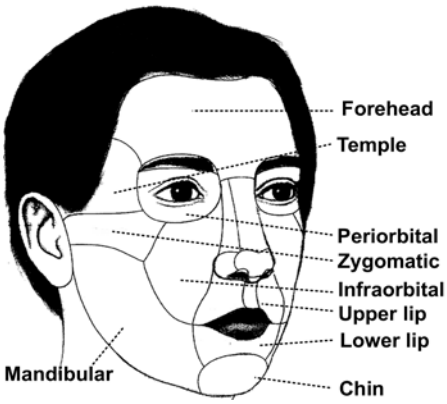
If the patient's loss meets the definition for facial reconstruction, the surgeon should:

- Check the box(es) for the area(s) of the patient's face that required surgery
- Fill in the date the first surgery was performed
- Certify the surgery by filling in his/her name and signing where appropriate

A member will be considered eligible for a TSGLI benefit for facial reconstruction if:

the member undergoes…	**AND…**
surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects. Note: In order to meet the standard for facial reconstruction, the member must experience a penetrating facial injury (avulsion) and lose bone or tissue that without replacement would leave a "gap" in the area of injury (discontinuity defect).	the surgery was to correct discontinuity loss to one of the following facial areas: the upper or lower jaw, 50% or more of the cartilaginous nose, 50% or more of the upper or lower lip, 30% or more of the left or right periorbita, 50% or more of any of the following facial subunits: · forehead, · left or right temple, · left or right zygomatic, · left or right mandibular, · left or right infraorbital · chin

Illustration of Facial Areas



Amputation of Hand

If the patient's loss meets the definition for amputation of hand, the medical professional should check the box(es) for amputation of left and/or right hand and fill in the date(s) of amputation.

A member is considered eligible for a TSGLI benefit for loss of hand if the member's hand is amputated at or above the wrist. The words "at or above" refer to the loss being closer to the body.

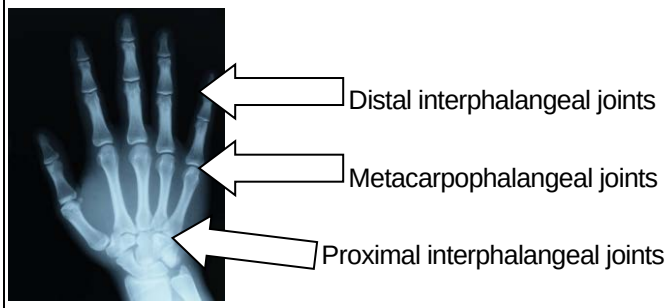
Amputation of Fingers

If the patient's loss meets the definition for amputation of fingers, the medical professional should:

- Check the box(es) for the fingers that were amputated
- Fill in the date(s) of amputation

A member will be considered eligible for a TSGLI benefit for amputation of fingers if:

the member suffers…	OR the member suffers…
Amputation of four fingers on the same hand (not including the thumb) at or above* the metacarpophalangeal joint	Amputation of thumb at or above* the metacarpophalangeal joint.

Amputation of fingers and or thumb at or above the metacarpophalangeal joint requires …
The loss of 4 fingers on the same hand or the loss of the entire thumb to the metacarpophalangeal joint as shown below:  Please be aware that the words "at or above" in the standard refers to the loss being "closer to the body" than the metacarpophalangeal joint – in other words, loss of the entire finger.

Amputation of Foot

If the patient's loss meets the definition for amputation of foot, the medical professional should check the box(es) for amputation of left and/or right foot and fill in the date(s) of amputation.

A member is considered eligible for a TSGLI benefit for loss of foot if:

the member suffers…	OR the member suffers…
Amputation of foot at or above* the ankle	Amputation of all toes (including the big toe) on the same foot at or above* the metatarsophalangeal joint.

**The words "at or above" in the standard refers to the loss being closer to the body.*

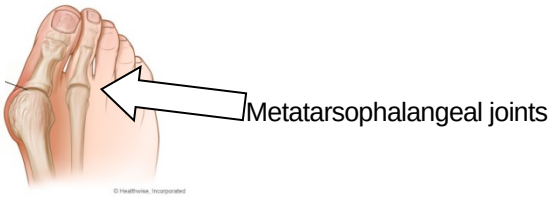
Amputation of Toes

If the patient's loss meets the definition for amputation of toes, the medical professional should:

- Check the box(es) for the toes that were amputated
- Fill in the date(s) of amputation

A member will be considered eligible for a TSGLI benefit for loss of toes if:

the member suffers…	OR the member suffers…
Amputation of four toes on one foot at or above* the metatarsophalangeal joint (not including the big toe)	Amputation of big toe at or above* the metatarsophalangeal joint.

Amputation of 4 toes or big toe at or above the metatarsophalangeal joint requires …
The loss of 4 toes on the same foot or the loss of the big toe to the metatarsophalangeal joint as shown below:    Please be aware that the words "at or above" in the standard refers to the loss being "closer to the body" than the metatarsophalangeal joint – in other words, loss of the entire toe.

Limb Salvage

If the patient's loss meets the definition for limb salvage, the surgeon should:

- Check the box(es) for the limb(s) being salvaged
- Fill in the date the first surgery was performed
- Certify the surgery by filling in his/her name and signing where appropriate

A member will be considered eligible for a TSGLI benefit for limb salvage if:

the member undergoes…	AND a surgeon certifies that…
A series of operations designed to avoid amputation of an arm or a leg while at the same time maximizing the limb's functionality. The surgeries typically involve bone and skin grafts, bone resection, reconstructive, and plastic surgeries and often occur over a period of months or years. Note: A complex leg or arm fracture does not automatically qualify as limb salvage. Limb salvage is based upon both the nature of the surgeries involved and whether the member's limb was medically at risk of amputation.	the patient is undergoing limb salvage surgery as defined in the column to the left.

Paralysis

If the patient's loss meets the definition of paralysis, the medical professional should:

- Check the box for the type of paralysis the patient has suffered
- Fill in the date of onset
-
- A member will be considered eligible for a TSGLI benefit for paralysis if:

the member suffers…	AND paralysis fall into one of these four categories
Complete paralysis due to damage to the spinal cord or associated nerves, or to the brain.	**Quadriplegia** - paralysis of all four limbs* **Paraplegia** - paralysis of both lower limbs*

	Hemiplegia - paralysis of the upper and lower limbs* on one side of the body **Uniplegia**- paralysis of one limb* *A limb is defined as an arm or a leg with all its parts.

Inability to Independently Perform Activities of Daily Living (ADL)

If the patient's loss meets the definition for inability to perform ADL, the medical professional should:

- Fill in the predominant reason the member is unable to perform ADL (TBI or other traumatic injury)
- Describe the injury and the reason(s) why the injury caused the patient to be unable to perform ADL

Description of injury - The medical professional should describe the patient's injuries and indicate what prevented the patient from performing the activities of daily living.

Example: The bones in both the patient legs were shattered and the patient is unable to get in or out of bed and go to and from the toilet.

- For each ADL the patient is unable to perform the medical professional should:
- Fill in the start and end date of the patient's inability to perform the ADL (if the patient is still unable to perform the ADL, check ongoing)
- Check the type(s) of assistance the patient required with the ADL (hands on, stand by or verbal)
- Describe the assistance needed with the ADL in the box provided

Assistance Needed – The medical professional should give information about the kinds of assistance needed in performing the ADL. Examples include, but are not limited to: unable to guide arms through shirtsleeves, on a feeding tube, must be sponge bathed by staff, constant bedpan usage, must be lifted into bed.

A member will be considered eligible for a TSGLI benefit for ADL if:

the member is…	AND the member's inability lasts for…
unable to independently perform* at least two of six ADL (bathing, continence, dressing, eating, toileting and transferring).	- at least 15 consecutive days for traumatic brain injury, OR, - at least 30 consecutive days for any other traumatic injury.

***When is the member considered to be unable to independently perform ADL?**

The member is considered unable to perform an activity independently if he or she REQUIRES assistance to perform the activity.

Requires Assistance is defined as:

- Physical assistance - when a patient requires hands-on assistance.

- Stand-by assistance - when a patient requires someone to be within arm's reach because the patient's ability fluctuates and physical or verbal assistance may be needed.

- Verbal assistance - when a patient requires verbal instruction in order to complete the ADL due to cognitive impairment. Without these verbal reminders, the patient would not remember to perform the ADL.

Without this physical, stand-by, or verbal assistance, the patient would be incapable of performing the task.

Accommodating Equipment/Adaptive Behavior - If the patient is able to perform the activity by using accommodating equipment, such as a cane, walker, commode, etc.) or the patient has developed other skills that allow him to perform the activity without assistance, the patient is considered able to independently perform the activity.

The table below should be used to help to determine whether a member has lost the ability to perform a particular ADL.

Patient is UNABLE to…	**…if he/she requires physical, stand-by, or verbal assistance* from another person…**
Bathe independently	to bathe more than one part of the body (via tub bath or sponge bath) or get in or out of the tub or shower.
Maintain continence independently	to manage catheter or colostomy bag. Patient is also unable to maintain continence independently if he/she is partially or totally unable to control bowel and bladder function.
Dress independently	to get and put on clothing, socks or shoes (may have help tying shoes).
Eat independently	to get food from plate to mouth, or take liquid nourishment from a straw or cup. The patient is also unable to eat independently if he/she is fed intravenously or by a feeding tube.
Toilet independently	to go to and from the toilet, get on and off the toilet, clean self after toileting, or get clothing off and on before and after toileting. The patient is also unable to toilet independently if he/she must use a bedpan or urinal.
Transfer independently	to move into or out of a bed or chair.

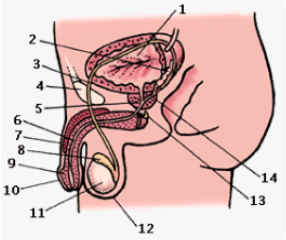
Genitourinary Losses

A patient meets the TSGLI standard for:

- **Anatomical Loss of the Penis** if he suffers amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body), OR damage to the glans penis or shaft of the penis that requires reconstructive surgery.

- **Permanent Loss of Use of the Penis** if he suffers damage to the glans penis **OR** damage to the shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.
- **Anatomical Loss of One Testicle** if he suffers the amputation of, or damage to one testicle that requires:
    - Testicular salvage,
    - Reconstructive surgery,
    - Or both.
- **Anatomical loss of both testicles** if he suffers amputation of, or damage to both testicles that requires:
    - Testicular salvage,
    - Reconstructive surgery,
    - Or both.
- **Permanent loss of use of both testicles** if he suffers damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

Male Genitourinary System



1 bladder, 2 seminal vesicle, 3 vas deferens, 4 pubic symphysis, 5 prostate, 6 urethra, 7 penis, 8 epididymis, 9 glans penis, 10 foreskin, 11 testicle, 12 scrotum, 13 Cowper's gland, 14 ejaculatory duct,

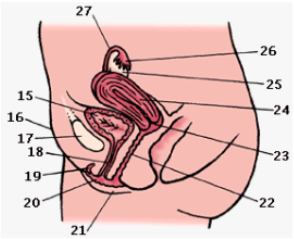
- **Anatomical loss of the vulva, uterus, or vaginal canal** if she suffers the complete or partial amputation of the vulva, uterus, or vaginal canal **OR**, damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery.

- **Permanent loss of use of the vulva or vaginal canal** if she suffers damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.

- **Anatomical loss of one ovary** if she suffers amputation of one or damage to one ovary that requires:
    - Ovarian salvage,
    - Reconstructive surgery,
    - Or both.
- **Anatomical loss of both ovaries** if she suffers amputation of both ovaries or damage to both ovaries that requires:
    - Ovarian salvage,
    - Reconstructive surgery,
    - Or both.

- **Permanent loss of use of both ovaries** if she suffers damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.

Female Genitourinary System



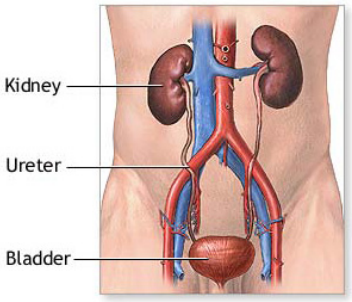
15 bladder, 16 mons pubis, 17 pubic symphysis, 18 urethra,
19 clitoris, 20 labia minora, 21 labia majora, 22 vagina,
23 cervix, 24 uterus, 25 ovary, 26 fimbria, 27 fallopian tube

- **Total and permanent loss of urinary system function** if the member suffers damage to the:
  - Urethra,
  - Ureter(s),
  - Both kidneys,
  - Bladder, or Urethral sphincter muscle(s)

    That requires:
  - Urinary diversion
  - Hemodialysis
  - Or both

  which is reasonably certain to continue throughout the lifetime of the member.

Urinary System



Other Useful Terminology Regarding Genitourinary (GU) Losses

The following medical terms are provided as examples of how some of the GU losses may be documented in medical records. These terms are only provided as a guide and are not to be considered as complete nor the only way that the GU losses are identified. These terms are provided only as a reference and are not intended to replace the genitourinary definition.

Genitourinary Loss	Medical Terms
1. Anatomical loss of the penis	Traumatic Penectomy Penoplasty or Phalloplasty
2. Permanent loss of use of the penis	Erectile Dysfunction Traumatic priapism
3. Anatomical loss of the testicle(s)	Traumatic Orchiectomy
4. Permanent loss of use of both testicles	Castration
5. Anatomical loss of the vulva, the uterus or the vaginal canal	Traumatic vulvectomy (simple and radical) Traumatic clitoredectomy Traumatic hysterectomy (uterus only) Traumatic vaginectomy (vagina only) Vulva ablation Vulva or Vulvar degloving Vulvoplasty
6. Permanent loss of use of the vulva or the vaginal canal	Sexual dysfunction Traumatic priapism
7. Anatomical loss of the ovary(ies)	Traumatic Oophorectomy
8. Permanent loss of use of both ovaries	Castration
9. Total and permanent loss of urinary system function	Nephrostomy (Urinary Diversion) Ureterostomy (Urinary Diversion) Hemodialysis

Section 3 - Other Information

The Other Information section provides additional information about the cause of the patient's losses. If the medical professional knows that the patient's losses are due to any of the reasons listed, the medical professional should provide an explanation in the box provided.

Section 4 - Medical Professional's Comments

The Medical Professional's Comments Section provides any additional information about the patient's injuries that may be helpful in processing the patient's claim. The medical professional should fill in any pertinent details about the patient's injury that are not otherwise indicated in Sections 1 through 3 of the application.

Section 5 - Medical Professional's Information

The Medical Professional's Information Section provides information about the medical professional completing Part B of the application. The medical professional should fill in all information requested.

Section 6 - Medical Professional's Signature

The medical professional must sign this section to certify the medical information provided. The medical professional should also indicate whether Part B was based on observation of the patient's loss or a review of the patient's medical records.

Benefit for Additional Losses from a Single Traumatic Event

A new complete TSGLI application is required when the member sustains additional losses, even if the loss resulted from a previous traumatic event already submitted on a TSGLI application.

> Example: A member permanently loses sight in one eye due to a traumatic event on April 1, 2012, and submits a TSGLI application for the loss. On May 1, 2012, the member loses one foot, as a direct result of a traumatic injury of the same traumatic event. The member must submit a second TSGLI application for the second loss.

Benefit for Additional Losses from Multiple Traumatic Events

A new complete TSGLI application is required when multiple traumatic events result in separate losses sustained by the Service Member. Multiple traumatic events must occur more than seven days (168 hours) apart from the initial traumatic event to be considered separate event.

> Example: A member suffers the loss of one foot on May 1, 2012 and submits a TSGLI application for the loss of foot. The same member suffers loss of sight in both eyes from another event that occurred on November 1, 2012. The member must submit a second TSGLI application for the loss of sight in both eyes.

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Part 6 - Certifying a Claim for TSGLI

General Information

The TSGLI office for the member's branch of service certifies TSGLI claims, making the eligibility determination for the benefit. A list of all TSGLI branch of service offices is provided in Appendix C. The certifying official must complete the TSGLI Certification Worksheet to indicate the disposition of the claim, and then forward the TSGLI application along with the worksheet and any other supporting documentation to the Office of Servicemembers' Group Life Insurance (OSGLI). Supporting documentation, in cases where the claim is denied in full or in part (the member is paid for some but not all of the losses claimed on the TSGLI Application), includes a copy of the letter the TSGLI branch of service office sent to the member explaining the losses approved (partial denials) and denied.

Instructions for Completing the TSGLI Certification Worksheet

The TSGLI Certification Worksheet provides information about the disposition of the member's TSGLI claim as well as tools for adjudicating the TSGLI claim. The Certification Worksheet is divided into 7 Sections:

1. Traumatic Event Information
2. Certification by Branch of Service
3. Disposition of Losses Claimed
4. Certifying Signature
5. Additional Comments
6. Service Member Address and Payment Information Update
7. Worksheets

The sections that are completed depend upon the type of claim being certified.

- ***For original claims and supplemental claims*** - the certifying official should complete Sections 1 – 5
- ***For appeals and reconsidered claims that are being approved*** – the certifying official should complete Sections 1 - 6

Section 1 – Traumatic Event Information

The Traumatic Event Information Section provides information about the traumatic event that caused the member's loss. Entries should be completed as follows:

Type of Claim – The certifying official should indicate the type of claim as follows:

- **Original claim** – the first claim by a member for a scheduled loss from a traumatic event
- **Supplemental claim** – a follow-up claim on an original claim from the same traumatic event but for an additional benefit for a new scheduled loss.
- **Appeal** - a claim that was originally denied by the branch of service TSGLI office, was reconsidered, and then reviewed by the branch's higher-level review organization for a final decision.
- **Reconsidered claim** – a claim that was originally denied by the branch of service TSGLI office but has been submitted for review by the claimant with new and substantial evidence.

Guardian, Power of Attorney or Military Trustee– The certifying official should indicate whether he/she is aware of a guardian, POA, or military trustee being appointed for the member

Date and Time of the Traumatic Event – The certifying official should enter the date and time of the event(using Zulu time) in the boxes provided.

Note: For non-penetrating blast injuries that occur more than seven full days apart AND whose cumulative concussive effects cause a single qualifying loss, the latest occurring verified blast injury should be used as the date of the traumatic event in order to give the member the longest two-year window to incur losses.

Was the member on duty when the event occurred? – The certifying official should indicate whether the member was on duty. The certifying official should base their determination for on duty on the following guidance:

Active Duty Members:

- On Duty
  - During actual performance of military training or duties, regardless of location
  - Examples:
    1. Member participating in physical training exercises.
    2. Member driving vehicle with military supplies or for military transport.
    3. Member on patrol at stateside base or combat location.
    4. Member completing weapons training class.
    5. Member working office-type military occupational specialty (Personnel Officer, IT, etc.)
    6. Member driving personal vehicle to military office or duty location.
- Off Duty
  - During any leisure time, including time where not on official leave but rather on "liberty" (authorized absence from place of duty and not chargeable to leave account)
  - Examples:
    1. Member playing baseball. (Any sporting activity that is not official training or duty).
    2. Member driving personal vehicle to dinner with friends.
    3. Member riding motorcycle on base or off base for pleasure.
    4. Member visiting family off base.
    5. Member doing home improvements at on base or off base housing
    6. Member injured in a bar or restaurant.
    7. Member injured while eating at mess hall.

  Note: For members on a Navy ship or in a combat zone, leisure activities, sleeping, or eating, would still be considered off duty.

Reserve and Guard Members:

- On Duty
  - During weekend drilling activities
  - Driving to and from weekend drilling activities
  - During annual training, if performing military training or duties
  - If activated for state or federal service, see guidance under "Active Duty Members"
  - Examples:
    1. Member participating in physical training exercises during weekend drills.
    2. Member driving vehicle with military supplies or for military transport during weekend drills.
    3. Member driving personal vehicle to and from weekend drills.
    4. Member performing military funeral honors duty.
    5. Member training in small arms fire during weekend drills or annual training.

- Off Duty
  - Anytime the member is not at weekend drills/annual training or driving to and from such training
    - Anytime the member is at weekend drills/annual training AND IS NOT performing military duties but rather on "liberty" (authorized absence from place of duty and not chargeable to leave account)
    - This would include sleeping, eating, or other leisure activities.

- Examples:
    1. Member playing baseball. (Any sporting activity that is not official training or duty).
    2. Member driving personal vehicle to dinner with family.
    3. Member injured on his/her private sector job.
    4. Member injured in a bar or restaurant.
    5. Member injured on vacation with family.
    6. Member injured while making home improvements.

Please note: This determination has no bearing on whether the claim is payable or not. TSGLI provides coverage for both on duty and off duty traumatic events. This information is being used solely for reporting and analysis purposes by VA.

Duty status at time of injury: The certifying official should indicate whether the member was attached to the Active, Reserve or National Guard component of their branch when their injury occurred. If the member is a Reservist or National Guard but was on active duty orders when the injury occurred, then Active Duty should be indicated.

Geographic Location and Hostile Action – the certifying official should indicate the geographic location where the event occurred and if the event was a hostile action. Certifying officials should attempt to avoid using latitude and longitude of event. In cases where the event occurred on a ship or airplane/helicopter, the certifying official should state the country (or state in the United States of America) in whose waters or airspace the ship or airplane/helicopter was located.

Description of Traumatic Event – The certifying official should enter a brief description of the traumatic event. Examples of traumatic events include:

- Military Motor Vehicle Accident
- Military Aircraft Accident
- Civilian Motorcycle Accident
- RPG Attack
- IED Attack
- Civilian Motor Vehicle Accident
- Civilian Aircraft Accident
- Small Arms Attack
- Training Accident (Please clarify with additional description)

Note: The certifying official should use the additional comments box on page 3 to enter additional information about the event that does not fit in the description box.

Important Note - Verifying the Traumatic Event -The certifying official should use available sources such as the Defense Casualty Information Processing System (DCIPS) or appropriate civilian records such as a police report to verify the date and time of the traumatic event, the location of the traumatic event, the description of the traumatic event, and the status of the member at the time of the traumatic event.

Deceased Service Member - If the Service Member is deceased, the certifying official must:

- Indicate the date and cause of death on the form
- Attach Report of Casualty (DD-1300) or civilian death certificate
- Attach SGLV 8286 indicating SGLI Beneficiary
- Note in the additional comments box on page 3 that the DD-1300 and SGLV 8286 are attached to the certification worksheet

Social Security Number – the claimant's social security number should be completed on the top right of all pages submitted as part of the Certification Worksheet.

Section 2 – Certification by Branch of Service

The Certification by Branch of Service Section indicates whether the member qualifies for TSGLI payment. The certifying official should indicate yes or no, and fill in the TSGLI payment amount they are certifying. The certifying official may use the worksheets on page 5 to help determine if the member is eligible for payment.

Section 3 – Disposition of Losses Claimed

The Disposition of Losses Claimed Section provides a list of all the TSGLI qualifying losses. The certifying official should review ***both*** Part A and Part B of the TSGLI application to determine which losses are being claimed by the member and whether the losses meet the standard for TSGLI payment. For each loss indicated in Parts A and B, the certifying official should:

- Indicate whether the loss is found or not found
- Enter the appropriate Disposition code for any claimed loss identified as not found
- Enter Disposition Code 15 for any loss that is found but cannot be paid because it can't be combined with another claimed loss
-

Indicating If Loss is Found or Not Found
Certifiers should use the following framework to determine if the loss is found or not found:

If the Member Claims a Single Loss

The loss is FOUND if…	the loss meets the standard for TSGLI payment and the loss is payable.
The loss NOT FOUND if…	the loss does not meet the standard for TSGLI payment.

If the Member Claims Multiple Losses

The loss is FOUND if…	The loss meets the standard for TSGLI payment and the loss is payable, **OR** The loss meets the medical standard for TSGLI, but due to program limitations, the loss is not payable. Example of program limitations: • Program maximum payment already reached • Program prohibits certain losses from being combined (i.e. limb salvage and amputation of same limb, loss of hand and loss of fingers of same hand, hospitalization for OTI and amputation of a limb)
The loss is NOT FOUND if…	The loss does not meet the standard for TSGLI payment, **OR** The loss was not evaluated because the maximum payment amount was certified.

Entering the Appropriate Disposition of Loss Code
The loss disposition codes listed on page 2 of the worksheet give 16 reasons for nonpayment of a claimed loss.
Codes 1 – 12 and 14 cover the reasons a loss is not found
Code 15 covers losses that are found, but cannot be combined with another loss due to program limitations.
Codes 13 and 16 cover losses not evaluated because the maximum payment amount for the claimed losses has been certified.
• The certifier should enter a code for any claimed loss identified as **not found** (codes 1-14, 16)
• any loss that is **found but cannot be paid** because it can't be combined with another claimed loss (code 15)

If more than one Loss Disposition Code applies to the loss, please list all that apply. If the reason is not covered by codes 1 through 16, the certifying official should use code 99 (other) and indicate the reason in the comments box.

The table below explains each of the loss disposition codes.

Code	Description	Use this code to indicate reason for non payment if…

Code	Description	Use this code to indicate reason for non payment if…
1	**Member was not covered under SGLI at the time of the traumatic event**	the member did not elect SGLI coverage and therefore was not covered by SGLI at the time of the traumatic event. *Note: Copy of SGLV 8286 must be attached showing declination of coverage.*
2	**Member's loss is not listed on TSGLI schedule of losses**	the loss the member is claiming is not listed on the TSGLI Schedule of Losses. Example: A member claims severe back pain with no loss of ADL. There is no such loss on the Schedule of Losses. The certifier should use Loss Disposition Code 2 to indicate denial.
3	**Medical documentation provided does not indicate the member's loss met the minimum TSGLI standard**	medical documentation does not show that the loss the member is claiming meets the standard indicated in the Procedures Guide for medically qualifying for the loss Example: A hospital release summary provided indicates that the member was hospitalized for 10 days and had loss of ADL due to TBI for 10 days. The certifier should use Loss Disposition Code 3 to indicate denial.
4	**Member did not suffer the loss within the prescribed period as defined by the regulation**	the loss the member is claiming occurred more than 730 days from the date of the traumatic event
5	**Member's loss was due to a physical or mental illness or disease other than those covered by TSGLI**	the loss the member is claiming is due to an illness or disease, except in the case of illnesses or diseases caused by pyogenic infection, biological, chemical or radiological weapon, or a contaminated substance. Example: Member claims loss of right leg on Part A. Medical professional documents loss of right leg on Part B but notes it is due to diabetes, not a traumatic event. The certifier should use Loss Disposition Code 5 to indicate denial.
6	**Member's loss was not a direct result of traumatic event**	the loss the member is claiming was not the direct result of a traumatic injury due to a traumatic event, but was caused in whole or in part by another factor. Example: A member falls and hits his head. Immediately after the incident, he experiences no after effects. Two months later the member has heart surgery. After the surgery, the member falls into a coma. The member claims the coma is due to the original fall but the medical professional indicates that it was due to the surgery. The certifier should use Loss Disposition Code 6 to indicate denial.
7	**Member did not survive for seven full days from the date of the traumatic event**	the member sustained a Scheduled Loss but did not survive seven full days from the date of the traumatic event.
8	**Member's loss was sustained while attempting to commit suicide**	the loss the member is claiming is due to a suicide attempt. Example: A member attempts to hang himself. He is unsuccessful but winds up in a coma for 15 days due to the attempt. The certifier should use Loss Disposition Code 8 to indicate denial

Code	Description	Use this code to indicate reason for non payment if…
9	**Member's loss was due to a traumatic injury willfully caused by a member's own actions**	the loss the member is claiming is due to their own actions Example: A member purposefully shoots himself in the leg to avoid military duty. He is hospitalized for 15 day due to this injury. The certifier should use Loss Disposition Code 9 to indicate denial.
10	**Member's loss was sustained while committing, or attempting to commit a felony**	the loss the member is claiming occurred while committing, attempting to commit a felony.
11	**Member's loss was caused by willful use of an illegal or controlled substance not prescribed by a doctor**	the loss the member is claiming is due to the willful use of an illegal or controlled substance not prescribed by a doctor.
12	**Member's does not meet requirements for retroactive payment because of date of loss**	the loss the member is claiming occurred prior to October 7, 2001.
13	**Member's loss was not evaluated because the loss cannot be combined with other losses paid.**	the claimed loss is not being evaluated because the member would not be able to receive additional payment since the loss cannot be combined with other approved losses. Example 1: A member suffers an amputation of a single extremity and is also claiming 30 days ADL loss due to OTI. Once the amputation has been verified through the medical records, the branch of service processing office does not review the ADL claim as it would not result in additional benefits being paid to the member. The certifier should use Loss Disposition Code 13 to indicate the loss was not reviewed. Example 2: A member suffers multiple facial reconstruction losses including reconstruction of the jaw. Once the jaw reconstruction has been verified through the medical records to meet the TSGLI standard, the branch of service processing office does not review any of the other claimed facial reconstruction losses since the $75,000 maximum for facial reconstruction losses has already been approved. The certifier should use Loss Disposition Code 13 to indicate these losses were not reviewed.
14	**Insufficient information to support the medical professional's statement**	the claim information and/or documentation does not support the claimed loss(es).
15	**Payment for this loss cannot be made in combination with other losses paid**	The loss the member is claiming cannot be combined with other losses (i.e. amputation and limb salvage of same limb)
16	**Member's loss was not evaluated because the maximum payment amount was certified**	the member is already being paid the maximum benefit and therefore the claim staff does not medically review other losses in order to pay the claim expeditiously. Example: A member suffers 2nd degree burns to 20% of the body. He qualifies for the maximum TSGLI payment. The member also claims loss of ADL for 120 days. The branch of service processing office does not review the ADL claim as the member is already being paid the maximum TSGLI benefit under burns. The certifier should use Loss Disposition Code 16 to indicate denial.
99	**Other**	the member's claim is not paid due to a reason other than indicated in Loss Disposition Codes 1-16. The certifier should explain why other was selected in the Comments box.

Sample Coding of Found/Not Found and Loss Disposition Code Boxes

Here are examples of coding for the certification worksheet in the following situations

- single loss claimed
- multiple losses claimed
- hospitalization and/or ADL loss

Single Loss Claimed

Example 1: Member loses left eye due to IED blast. Certifier would check Found box and would not enter anything in the Loss Disposition Code box.

Loss	***Found***	***Not Found***	***Code(s)***
Sight - left eye	☑	☐	

Example 2: Member loses peripheral vision in left eye due to IED blast. Limits to peripheral vision do not result in 30 degree or less peripheral vision. Certifier would check Not Found box and would enter Loss Disposition Code 3.

Loss	***Found***	***Not Found***	***Code(s)***
Sight - left eye	☐	☑	3

Example 3: Member goes into a coma for 30 days due to a stroke. Certifier would check Not Found for Coma 15 days and Coma 30 days box and would enter Loss Disposition Code 5 for both.

Loss	***Found***	***Not Found***	***Code(s)***
Coma 15 days	☐	☑	5
Coma 30 days	☐	☑	5

Note: For Single Loss Claimed situations, Loss Disposition Codes 15 & 16 do not apply.

Multiple Losses Claimed

Example 1: Member is an MV accident and suffers amputation of both legs. Certifier would check Found boxes for amputation of left and right foot and place no entry in the Loss Disposition Codes for either one.

Loss	***Found***	***Not Found***	***Code(s)***
Amputation - left foot	☑	☐	
Amputation - right foot	☑	☐	

Example 2: Member is injured in a MV accident and suffers amputation of both legs as well as 2nd degree burns on 20% of body. Certifier would check Found boxes for amputation of left and right foot and burns. No Loss Disposition codes should be entered.

Loss	***Found***	***Not Found***	***Code(s)***
Amputation - left foot	☑	☐	
Amputation - right foot	☑	☐	
Burns to the body	☑	☐	

Example 3: Member is injured in a MV accident and suffers an amputation of his right arm. Member claims both amputation of right arm and amputation of right thumb. Certifier would check Found boxes for amputation of right hand and amputation of right thumb. Certifier would enter no Loss Disposition Code for amputation of right arm and Loss Disposition Code 15 for amputation of right thumb.

Loss	***Found***	***Not Found***	***Code(s)***
Amputation – right arm	☑	☐	
Amputation - right thumb	☑	☐	15

Example 4: Member is injured in a MV accident. Member is hospitalized for 10 days and suffers loss of two ADL for 20 days due to Other Traumatic Injury. Certifier would enter Not Found for both Hospitalization – 15 days and ADL 30 days due to OTI. Certifier would also enter Loss Disposition Code 3 for both items.

Loss	***Found***	***Not Found***	***Code(s)***
Hospitalization - 15 days	☐	☑	3
ADL 30 days due to OTI	☐	☑	3

Example 5: Member is injured in a MV accident and claims 2nd degree burns on 20% of body and loss of two ADL due to Other Traumatic Injury for 120 days. Branch does not evaluate ADL loss as burns already provide maximum benefit. Certifier would check Found box for burns and place no Loss Disposition Code by burns. Certifier would check Not Found box for 30 days ADL due to OTI, 60 days ADL due to OTI, 90 days ADL due to OTI, and 120 days ADL due to OTI, and enter Loss Disposition Code 16 for each increment.

Loss	***Found***	***Not Found***	***Code(s)***
Burns to the body	☑	☐	
ADL30 days due to OTI	☐	☑	16
ADL 60 days due to OTI	☐	☑	16
ADL 90 days due to OTI	☐	☑	16
ADL120 days due to OTI	☐	☑	16

Inpatient Hospitalization and ADL losses

If the member is claiming inpatient hospitalization and/or ADL loss, there are two situations that may be coded.

1. Member claims inpatient hospitalization in combination with subsequent ADL loss
2. Member claims multiple increments of ADL loss

To ensure uniformity in coding, each of these situations should be coded as follows:

1) Member claims inpatient hospitalization in combination with subsequent ADL loss – the certifier should check found or not found for both inpatient hospitalization (which replaces the first ADL milestone), and the second and any subsequent ADL milestones.

Example 1: Member is injured in a MV accident on July 4, 2008. Member is hospitalized for 15 days and suffers loss of two ADL for an additional 45 days due to Other Traumatic Injury. Both losses meet the standard for TSGLI payment. The certifier would check Hospitalization – 15 days and ADL 60 days due to OTI.

Loss	***Found***	***Not Found***	***Code(s)***
Hospitalization - 15 days	☑	☐	
ADL 60 days due to OTI	☑	☐	

Example 2: Member is injured in a MV accident. Member is hospitalized for 15 days and suffers loss of two ADL for an additional 95 days due to Other Traumatic Injury. Both losses meet the standard for TSGLI payment. The certifier would check Hospitalization – 15 days, ADL 60 days due to OTI, and ADL 90 days due to OTI.

Loss	***Found***	***Not Found***	***Code(s)***
Hospitalization - 15 days	☑	☐	
ADL 60 days due to OTI	☑	☐	
ADL 90 days due to OTI	☑	☐	

2) Member claims multiple increments of ADL loss – The certifier should check found or not found for each increment of ADL loss.

Example 1: Member is injured in a MV accident. Member is claims loss of two ADL for 120 days due to Other Traumatic Injury, and member meets the standard for TSGLI payment for 120 days ADL. The certifier would check found for each increment of ADL loss.

Loss	***Found***	***Not Found***	***Code(s)***
ADL 30 days due to OTI	☑	☐	
ADL 60 days due to OTI	☑	☐	
ADL 90 days due to OTI	☑	☐	
ADL 90 days due to OTI	☑	☐	

Example 2: Member is injured in a MV accident. Member is claims loss of two ADL for 90 days due to TBI, but the medical professional's statement only supports 60 days of ADL loss. The certifier would check found for the first 3 increments of ADL loss, not found for the fourth increment of ADL loss and would enter Loss Disposition Code 3.

Loss	***Found***	***Not Found***	***Code(s)***
ADL 15 days due to TBI	☑	☐	
ADL 30 days due to TBI	☑	☐	
ADL 60 days due to TBI	☑	☐	
ADL 90 days due to OTI	☐	☑	3

Section 4 - Certifying Signature

The certifying official must complete and sign this section to certify the TSGLI claim.

Section 5 - Additional Comments

The Additional Comments Section should be used to provide information that will clarify anything previously listed on the application. This includes:

- further details of the traumatic event,
- explanation of the losses (such as ADL),
- and any questions or issues that may be of concern.

Section 6 – Service Member Address and Payment Information Update

The Service Member Address and Payment Information Update Section is used to ensure the address and payment information for the claim is accurate when submitting reconsiderations and appeals.

The certifying official should complete and submit Section 6 to OSGLI only if the original decision by the branch of TSGLI office has been overturned to:

- Pay the claimant when previously denied
- Pay more money than originally certified for

In cases where reconsideration or appeal upholds the original decision, Section 6 does not need to be completed. In either case, the branch of service TSGLI office should email OSGLI at the appeals mailbox with all information requested.

The certifying official should contact the claimant (or guardian, power of attorney, or military trustee) to verify address, guardianship/trustee and payment option information. This section should be completed as follows:

Checkbox for prior certification – the certifying official should check this box to certify that any information not filled in on this application has not changed since the original claim was filed

Service Member's Current Address & Contact Information – the certifying official should fill in member's contact information if it is different from the original claim. If there is no change, leave the section blank.

Guardian, Power of Attorney, or Military Trustee Information - the certifying official should fill in member's guardian/POA/military trustee information if it is different from the original claim. If there is no change, leave the section blank.

Payment Option - the certifying official should fill in member's payment option information if it is different from the original claim. If there is no change, leave the section blank.

The certifying official should then forward the following items to OSGLI to certify the appeal/reconsideration:

- A copy of the original claim
- A completed Certification Worksheet including Section 6

Section 7 - Checklists

The Checklists Section contains checklists that can be used by the certifying official to determine eligibility for TSGLI payment. These checklists should not be sent to OSGLI.

Additional Information Required When Original or Supplemental Claims are Fully or Partially Denied

In cases where the member's original or supplemental claim is denied in full or in part (the member is paid for some but not all of the losses claimed on the TSGLI Application), the TSGLI certifying official must submit, in addition to the TSGLI Application and TSGLI Certification Worksheet, a copy of the denial letter the TSGLI branch of service office sent to the member explaining the losses paid (if a partial denial) and the reason for denial of any losses that were not approved.

Submitting the Application to OSGLI

The certifying official of the member's branch of service will submit the application to OSGLI via email or fax. The email address is tsgli.appeals.claims@prudential.com. The fax number is 1-877-832-4943. The branch of service should submit all original TSGLI claims to OSGLI, even if they are denying the claim. The branch of service should submit reconsidered or appealed TSGLI claims to OSGLI if there is a change in the decision in order for OSGLI to issue payment. In cases where there is no change in the decision and the same losses were claimed, the branch of service should notify OSGLI at the same email address as noted above indicating that the case was reconsidered or appealed and the decision remains unchanged. See Part 8, specifically the section titled "Reporting of Denied Claims and Appeals" for complete reporting requirements.

Submitting Multiple Applications to OSGLI

Additional Losses from a Single Traumatic Event

A new complete TSGLI application is required when the member sustains additional losses, even if the loss resulted from a previous traumatic event already submitted on a TSGLI application. In these instances, the certifying official should check the box for "Supplemental Claim" in Section 1, Traumatic Event Information.

> Example: A member permanently loses sight in one eye due to a traumatic event on April 1, 2012, and submits a TSGLI application for the loss. On May 1, 2012, the member loses one foot, as a direct result of a traumatic injury due to he same traumatic event. The member must submit a second TSGLI application for the second loss.

Additional Losses from Multiple Traumatic Events

A new complete TSGLI application is required when multiple traumatic events result in separate losses sustained by the Servicemember. Traumatic events must occur more than seven days (168 hours) apart from the initial traumatic event to be considered a separate traumatic event(s).

> Example: A member suffers the loss of one foot on May 1, 2012 and submits a TSGLI application for the loss of foot. The same member suffers loss of sight in both eyes from another event that occurred on November 1, 2012. The member must submit a second TSGLI application for the loss of sight in both eyes.

Instructions for Using the Medical Professional's Supplemental Statement

The Medical Professional's Supplemental Statement should be used by the TSGLI certifying official to request additional information from the medical professional when it is needed to adjudicate the TSGLI claim. This information will then be made a part of the member's TSGLI claim. The statement has 4 sections:

1. Request for Supplemental Medical Information
2. Medical Professional's Supplemental Statement
3. Medical Professional's Information
4. Medical Professional's Signature

Section 1 – Request for Supplemental Medical Information

To request additional information, the certifying official should fill in:

- The member's name and social security number (on both pages of the form)
- The name, address, phone and fax number of the branch of service TSGLI office requesting the information
- The specific information requested or section of Part B that needs clarification

The certifying official should then mail or fax the request form to the medical professional.

Sections 2 through 4 - Medical Professional's Supplemental Statement, Information and Signature

The medical professional should complete these sections to provide and certify the requested information. The medical professional can use the form provided or submit additional sheets and attach it to the Supplemental Medical Form. The completed statement should then be mailed or faxed to the branch of service TSGLI office.

Submitting Medical Professional's Supplemental Statement to OSGLI

The Medical Professional's Supplemental Statement, just like other additional medical evidence submitted with the claim, does NOT need to be sent to OSGLI with the Claim Form and Certification Worksheet when the claim is certified.

Part 7 - Payment of TSGLI Benefits

General Information

Payment of TSGLI benefits will be in accordance with the published schedule of loss in 38 CFR 9.20 (see Part 4, Schedule of Losses). The Office of Servicemembers' Group Life Insurance issues payments after a claim is certified for by payment by the member's branch of service TSGLI processing office.

TSGLI Beneficiary

The beneficiary of the TSGLI benefit is the member. If the member is incompetent, payment will be made to the guardian, power of attorney, or military trustee. Prudential's Alliance Account* is not available to the guardian or power of attorney.

If the member dies after qualifying for payment, the payment will be made to the member's listed SGLI Beneficiary(ies). The member must survive for seven days (168 hours) from the date of the traumatic event to be eligible for TSGLI.

Taxes

The IRS has determined that the TSGLI benefit is not taxable and does not need to be reported to the IRS.

Note: In cases of overpayment where the funds have not been returned, the benefit maybe taxable.

Methods of Payment

There are three methods of payment for TSGLI benefits:

1) Lump Sum - Prudential's Alliance Account®*
2) Electronic Funds Transfer (EFT)
3) Lump Sum - Check

1) Lump Sum - Prudential's Alliance Account®*

The benefit will be deposited into Prudential's Alliance Account in the member's name. The Alliance Account is a personal interest bearing account, which gives the member ready access to the money, whenever it is needed. To use the account, the member can simply write a check for the withdrawal amount. The member may write checks as the money is needed or write out one check for the entire amount and close the account. The account will continue to earn interest as long as any balance is maintained in the account. The member cannot deposit any additional monies into the Alliance Account. (this paragraph explains what will happen)

*An Alliance Account is an interest bearing draft account established in the beneficiary's(ies') name(s) with a draft book. The beneficiary can write drafts ("checks") for any amount up to the full amount of the proceeds. There are no monthly service fees or per check charges and additional checks can be ordered at no cost, but fees apply for some special services including returned checks, stop payment orders and copies of statements/checks.

The Bank of New York Mellon is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Draft clearing and processing support is provided by The Bank of New York Mellon. **Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC).** The Bank of New York Mellon is not a Prudential Financial company.

Guardians, Power of Attorneys, Military Trustees: A Service Member's legal guardian, military trustee, or power of attorney (POA) may choose the Alliance Account payment option as long as they submit proof of that

appointment (i.e. the appropriate documentation) with the claim. The guardian, military trustee, or POA will not have their name added to the account, but will be able to sign Alliance Account checks on behalf of the member.

If the member is competent at time of application and opens an Alliance Account and later becomes incompetent, a guardian, power of attorney, or military trustee can submit that documentation to Alliance Account and gain access to the funds in the account. To do this, a guardian, power of attorney, or military trustee should contact Alliance Customer Service toll free at 877-255-4262 or the OSGLI Claim Department toll free at 800-419-1473.

2) Electronic Funds Transfer (EFT)

The TSGLI benefit will be electronically credited to the bank account specified. This account should be the account of record for payroll purposes. Depending on the member's bank, payments will be credited three to five days from the date the payment is authorized.

Note: If the member does not choose EFT and there is no guardian power of attorney, or military trustee, the payment will be made through Prudential's Alliance Account.

Access to Funds by Other Parties: Members should be advised that once the TSGLI payment is electronically credited the bank account specified, anyone who has access to the account (i.e. spouse or children) can access the money.

3) Lump Sum Check

Payment will be made by check only to a guardian, power of attorney, or military trustee. This option is not available to the member.

Beneficiary Financial Counseling Services (BFCS)

BFCS is available to the TSGLI recipient. BFCS provides no cost personal financial counseling to TSGLI recipients on how best to use their benefit to meet their needs. The recipient will be notified of this benefit and how to access it when they receive the TSGLI payment.

Part 8 – The Denial and Appeals Process

General Information

The following are key terms for denial and appeal processing:

1. **Denial**: The disapproval of a claim for benefits by the TSGLI branch of service office.
2. **Full Denial**: The TSGLI branch of service office denies all losses claimed by the member.
3. **Partial Denial**: The TSGLI branch of service office approves some of the losses and denies others claimed by the member.
4. **Appeal:** The actions taken by the member to seek a review of the denial decision by the TSGLI branch of service office. This can include requesting a review through the internal branch of service review process or initiating legal action in federal district court.

Appeal Period

When the branch of service denies a member's TSGLI claim, the member has one year from the date of decision to appeal the decision. The member must communicate his/her intent to appeal in writing within this one-year period. The TSGLI Appeal Request Form (SGLV-8600A) may be required when filing an appeal. The member should review their previous decision letter for instructions on where to submit their appeal and whether the SGLV-8600A is required. The form is available from the branch of service or the Department of Veteran's Affairs Insurance website at **www.benefits.va.gov/insurance**.

The one-year appeal period only applies to subsequent claims that do not include "new and material evidence". In effect, this means that all claims with new and material evidence are new claims that the TSGLI branch of service office will adjudicate regardless of how long after the original decision the claim is submitted.

VA uses the terms new and material as follows (See 38 CFR 3.156):

- **New**: Evidence is new if it has not previously been considered.
- **Material**: Evidence is material if, by itself, or when considered with previous evidence of record, it tends to prove an unestablished fact necessary to substantiate the claim.

New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last final denial and must raise a reasonable possibility of substantiating the claim. Evidence is cumulative, and thus, not material, if it:

- reinforces a previously proven or conceded element of the claim
- provides additional details to support previous statements, or
- rehashes previously submitted statements

New and material evidence may take many forms. Examples include:

- written and sworn testimony of the claimant or witnesses to an event,
- a medical nexus opinion with supporting rationale, and
- unconsidered service department records.

Appeal Period Example 1 – No New and Material Evidence: Member injured in a motor vehicle accident. Member sends in police report and treatment records from hospital, all treating physicians, and outpatient therapy. Member claims loss of two ADL for 30 days due to Other Traumatic Injury. Member's claim is denied on August 1, 2014. On December 15, 2015, member submits additional treatment records from hospital stay that were not submitted with original claim. However, the new treatment records do not provide any new information. Rather, they reinforce the same facts as in the original claim. While the information submitted is new, it is not material. In this case, the member's new information would not be reviewed as the one-year appeal period has already ended.

Appeal Period Example 2 – No New and Material Evidence: Member was injured in a house fire. Member sends in police report and treatment records from hospital, all treating physicians, and outpatient therapy. Member claims Burns. Member's claim is denied on June 1, 2014. On August 17, 2015, member resubmits the original claim form with the same evidence as that was provided with the original claim. The new claim does not contain new or material evidence. In this case, the member's subsequent claim would not be reviewed as the one-year appeal period has already ended.

Appeal Period Example 3 –New and Material Evidence: Member was injured in a fall from his roof. Member sends in treatment records from hospital. Member claims loss of two ADL for 60 days due to Other Traumatic Injury. Member's claim is denied on November 8, 2014. On December 30, 2015, member submits additional outpatient therapy records for ongoing treatment for severe back injury. The outpatient therapy records were not submitted previously; so they are new. The outpatient therapy records also provide material information on the nature and length of the ADL losses. Because the evidence is new and material, the member has initiated a new claim and the one-year appeal period does not apply. The new evidence will be reviewed and a new claim adjudicated.

Types of Appeals Handled by the Branch of Service

Appeals must be submitted, in writing, to the appropriate branch of service.

Appeals to the branch of service should contain the following information:

- Identifying information (e.g. name, address, social security number)
- The reasons why the member disagrees with the determination
- Documentation in support of the member's claim (e.g. medical records, Physical Evaluation Board Findings)
- Written comments, documents, records and any other information relating to their claim

Appendix D provides the appropriate point of contact in each branch of service for the handling of TSGLI appeals and the organization that completes each level of review.

Most Frequent Decisions Likely to be Appealed to the Uniformed Service

The following is a list of the most frequent decisions that would need to be appealed to the uniformed services:

1) Decision that a member's loss did not meet the requirements for a loss under TSGLI
2) Decision that the member's loss did not occur within 730 days of the traumatic event causing the loss
3) Decision that the member's loss was not the direct result of a traumatic injury..
4) Decision that the member's loss was due to a physical or mental illness or disease other than those covered under TSGLI
5) Decision that the member's loss is due to a traumatic injury willfully caused by the member's own actions
6) Decision that the member's medical treatment (e.g. surgery), in and of itself, is not considered a traumatic event
7) Decision that the member was not covered by SGLI at the time of the traumatic event (only for injuries occurring on or after December 1, 2005), and therefore was not covered by TSGLI

1) Decision that a member's loss did not meet the requirements for a loss under TSGLI

The member's claim is denied because the member's loss did not meet the requirements outlined in the schedule of losses (see Part 4, Schedule of Losses).

> Example: A member is injured in a car accident. As a result of the car accident he suffers 2nd degree burns on 10 percent of his body. His claim is denied because the requirement for payment is that the burns not only be 2nd degree but cover 20 percent of his body. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

2) Decision that the member's loss did not occur within 730 days of the traumatic event causing the loss

The member's claim is denied because the member's loss did not occur within 730 days of the traumatic event (see Part 1, Qualifying for TSGLI Payment)

> Example: A member is injured in a training accident on April 15, 2010. As a result of the accident she suffers reduced vision in her right eye, but her loss of vision does not meet the TSGLI standard. Over the next two years her vision becomes progressively worse. On June 15, 2012, her visually acuity measurement meets the standard for TSGLI and she files a claim. The claim is denied because her loss occurred more than 730 days from the traumatic event causing the loss. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within her uniformed service.

3) Decision that the member's loss was not the direct result of a traumatic injury

The member's claim is denied because the member's loss was not the direct result of a traumatic injury but from some other cause (see Part 1, Qualifying for TSGLI Payment).

> Example: A member falls and hits his head. After the event, he appears fine and continues to function normally. A month later, he takes some prescribed medication for a heart condition and soon after falls into a coma. The member's power of attorney claims the coma is the direct result of damage to his brain due to the fall (a traumatic injury); however, the member's medical professional states that the medication from his heart condition is the likely cause of the coma (a separate cause). The claim is denied as the member's loss was not the direct result of a traumatic injury but from some other cause. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within his uniformed service.

4) Decision that the member's loss was due to a physical or mental illness or disease other than those covered under TSGLI

The member's claim is denied because the member's loss was due to mental illness or disease and that illness or disease was not caused by:

- a pyogenic infection or,
- biological, chemical, or radiological weapons or,
- accidental ingestion of a contaminated substance

  (see Part 1, Injuries Excluded from TSGLI Coverage)

Example 1: A member was involved in a small arms battle where he suffered a non-life threatening injury and also saw his friend get killed. He returns home and begins having nightmares and is so severely depressed that he cannot do two of the activities of daily living on his own (dressing and eating) for 30 days. His doctor diagnoses him with Post-Traumatic Stress Disorder (PTSD). The claim is denied because the loss (the inability to dress or eat without assistance) for 30 days is the result of a mental illness and that illness was not caused by a pyogenic infection or by biological, chemical, or radiological weapons or accidental ingestion of a contaminated substance. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

Example 2: A member has diabetes and her condition begins to cause problems to her leg resulting in the amputation of her leg. The claim is denied because the loss was due to a disease not covered by TSGLI. To appeal this denial of TSGLI benefits, the member must submit her appeal to the appropriate contact within her uniformed service.

5) Decision that the member's loss is due to a traumatic injury caused by the member's own actions

The member's claim is denied because the member's loss was due to a traumatic injury caused by one of the following actions on the part of the member:

- Attempting to commit suicide;
- Intentionally self-inflicted injury or an attempt to inflict such injury;
- The member's willful use of an illegal or controlled substance, unless under the advice of a doctor; or
- Committing or attempting to commit a felony.

(See Part 1, Injuries Excluded from TSGLI Coverage)

Example: A member is injured in a motorcycle accident. After a police investigation, it is determined that the member was driving 100 miles per hour and rolled his motorcycle because he was high on crack cocaine. As a result of the accident he has a spine injury and is now a paraplegic. The claim is denied because the loss is due to the member's willful use of an illegal substance. To appeal this denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

6) Decision that the member's medical treatment (e.g. surgery), in and of itself, is not considered a traumatic event

The member's claim is denied because the member's loss was due to a loss caused by medical treatment and medical treatment, in and of itself, is not considered a traumatic event. (See Part 1, Injuries Excluded from TSGLI Coverage)

Example: A member goes into the hospital on June 1st for surgery related to a brain aneurysm. During the surgery, the member goes into a coma and remains in a coma for 60 days. The claim is denied because the loss is due to the medical treatment for a brain aneurysm. To appeal the denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

7) Decision that the member was not covered by SGLI at the time of the traumatic event (only for injuries occurring on or after December 1, 2005), and therefore was not covered by TSGLI

The member's claim is denied because records indicate that the member declined SGLI coverage on their most recent SGLI Election and Certificate prior to their injury, and therefore the member was not covered by SGLI or TSGLI at the time of the traumatic event.

> Example: A member completes a SGLI Election and Certificate (SGLV 8286) upon entering the service in March 2013 indicating that he does not want SGLI coverage. One year after entering the service, the member is deployed to Afghanistan. While in Afghanistan, the member is injured by an IED blast and has his left leg amputated. The claim is denied because the member was not covered by SGLI at the time of his injury. To appeal the denial of TSGLI benefits, the member must submit his appeal to the appropriate contact within his uniformed service.

The TSGLI Appeal Request Form (SGLV-8600A)

The TSGLI Appeal Request Form (SGLV-8600A) is used when filing an appeal for previously denied benefits under the Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program. . The member should review their previous decision letter for instructions on where to submit their appeal and whether the SGLV-8600A is required. The form is available from their branch of service TSGLI Office or the Department of Veteran's Affairs Insurance website at www.benefits.va.gov/insurance.

- To avoid delays in the review process, please highlight any new and material evidence within medical records and submit only the new evidence/documentation that supports the appeal. There is no need to resubmit all previously submitted documents as they will be considered when your appeal is reviewed.

Completing Form SGLV-8600A

The first page of the application provides contact information about the TSGLI Branch of Service Offices.

Who Makes the Decision on My Appeal?

This section of the form contains eight areas:

1. Servicemember name
2. Social Security Number (last four) and Date of Birth
3. Mailing address
4. Phone number and Email address
5. Date of Traumatic Event/Injury and Location of Traumatic Event/Injury
6. List Losses from TSGLI Schedule of Losses that are being appealed (List **only** those losses that are being appealed)

   a. Third Party Authorization and/or Guardian, Power of Attorney or Military Trustee information

   This is an optional section and not required Itmay be left blank if

   not appropriate
7. Reason for appeal

   a. There are ten basic reasons for an appeal that can be selected with one additional "Other" reason that is not listed. **(check all that apply)**

b. Please highlight any new and material evidence within medical records and **submit only the new evidence/documentation that supports the appeal**

c. Do not resubmit evidence that was already submitted previously.

8. Additional supporting information and details you specificly want considered on your appeal.

    a. Any additional information not already provided should be explained here.

Banking Information

The form asks if the member'sbanking information changed since their last claim was submitted or if they want to change the payment method. This ensures payment will be made through the desired method and/or to the appropriate account number, should the claim be approved on appeal.

1. If banking information has changed from the last submitted claim, select "Yes"

    a. If the claim is approved onappeal, the TSGLI Processing Office will contact the member for new banking information.

2. If banking information has not changed from the last submitted claim, select "No"

    a. If the claim is approved on appeal, the TSGLI payment will be released to the same account provided on the member's prior claim.

3. Signature and Date

Denials and Appeals Processing

Denials Processing

Denials of TSGLI benefits by the branch of service need to be submitted to OSGLI for comprehensive record keeping purposes and preparation.

For all denials of claims (original claims and appeals):

1. The branch of service will send formal denial letters to all claimants whose TSGLI claim is denied. These letters will explain the reason for denial and an explanation of the member's appeal rights, both through the TSGLI branch of service office's internal appeal process and through the courts. The letters will provide a clear explanation of what information the member needs to submit if they desire to appeal the decision and the office to which the appeal should be directed with the branch of service.
2. The TSGLI branch of service office will notify OSGLI of the denial and provide information on the denied claim as noted in "Reporting of Denied Claims and Appeals" below.
3. OSGLI will record the denial in its' records.

For denials of original claims (an initial claim from the member, a supplemental claim with additional losses that were not previously claimed, and a subsequent claim based on a new traumatic event):

1. The branch of service will send formal denial letters to all claimants whose TSGLI claim is denied. These letters will explain the reason for denial and an explanation of the member's appeal rights, both through the TSGLI branch of service office's internal appeal process and through the courts. The letters will provide a clear explanation of what information the member needs to submit if they desire to appeal the decision and the office to which the appeal should be directed with the branch of service.
2. The TSGLI branch of service office will provide a copy of this letter, along with the TSGLI Application and Certification Worksheet to OSGLI when certifying the claim.

3. OSGLI will record the denial in its' records.

In the case of partial denials, OSGLI will not only record the denial in its's records, but also issue payment to the member for the losses approved. In the case of full denials, OSGLI will only record the denial in its' records.

Appeals Processing

Each branch of service has its own administrative appeals process. Each organization's appeals process has three levels of review, as shown below.

> Note: The first level of review is considered by the branches to be a "reconsideration" of a claim and is done by the branch of service TSGLI office. The second and third level reviews are completed by completely separate organizations within each branch of service.

Organization	1st Level Review	2nd Level Review	3rd Level Review
Army	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	U.S Army TSGLI Appeals Board	U.S. Army Review Board Agency
Navy	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	TSGLI Appeals Board Navy Council of Review Boards	Board for Correction of Naval Records (BCNR)
Air Force – Active	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	USAF Physical Disability Division, HQ AFPC/DPFD	Board for Correction of Air Force Records SAF/MRBR
Air Force - Reserve	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	USAF Physical Disability Division, HQ ARPC/DPTTB	Board for Correction of Air Force Records SAF/MRBR
Air National Guard	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	Air Force Surgeon General National Guard Bureau/A1PS	Board for Correction of Air Force Records
Marine Corps	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.	TSGLI Appeals Board Navy Council of Review Boards	Board for Correction of Naval Records (BCNR)
Coast Guard	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.		
Public Health Service	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.		
National Oceanic and Atmospheric Administration	The first level of review is considered by the branches, a "reconsideration" of a claim and is done by the branch of service TSGLI office.		

Right to Sue in Federal Court

In addition to utilizing the administrative appeals process, members have the right to file suit in federal court to contest an adverse TSGLI decision. All TSGLI denial letters inform members of this right.

In the event a member files suit in federal court, the branch of service must provide OSGLI with any documents and records relating to the initial TSGLI denial and any subsequent appeals.

Denial and Appeal Records

Both the branch of service and OSGLI maintain certain records in the case of denials and appeals.

Denial Records

1) Records the Branch of Service Maintains

The branch of service maintains the following records (or copy of such records) for denials of claims by their service:

- A TSGLI application for each denial
- Any medical or other documentation used to substantiate a decision to deny the claim
- The letter sent to the member informing them of the denial and their appeal rights

2) Records OSGLI Maintains

OSGLI maintains the following records (or copy of such records) for **all** denials of claims:

- A record of all denied claims and the reasons for denial
- A TSGLI application for each denial
- The letter sent to the member informing them of the denial and their appeal rights

Appeal Records

Records the Branch of Service Maintains

The branch of service maintains the following records (or copy of such records) on all appeals directed to them:

- The member's letter indicating he/she is appealing the uniformed service's decision
- All materials provided by the member, the branch of service, or VA used in a review of the original decision on appeal
- The letter sent to the member informing them of the branch of service's decision on appeal

Reporting of Denied Claims and Appeals

Denied Claims

Comprehensive reports of denied claims can be obtained through OSGLI. OSGLI is the only organization maintaining centralized records on denials for all branches of service.

Branch of service points of contact are able to print their own denied claims reports on-demand through OSGLI's web reporting capabilities. If there is a new branch of service point of contact or if the point of contact is having problems with web reporting, contact the TSGLI Business Analyst at OSGLI at 800-419-1473.

Appeals

Branch of service appeals points of contact must provide information on all appeal activity to OSGLI. They should provide the following information to OSGLI:

- Name of member appealing
- Social Security number of member appealing
- Dates of Appeal (at each level)
- Copy of all letters sent by the member to the branch of service

- Review status within branch of service (level of appeal) – submit information at each level of review
- Copy of all letters sent by the branch of service to the member in response to the appeal
- Final decision on appeal

All required information should be sent to: tsgli.appeals.claims@prudential.com. OSGLI will take the information sent to this email box and associate it with the member's TSGLI file.

Denial and Appeals Process at Each Level of Appeal

The information below discusses the sequence of events involved in a denial and appeal on an issue appealed to the branch of service.

Original Denied Claim

The member initially submits the TSGLI application to the branch of service. The TSGLI branch of service office sends the member a letter denying the TSGLI benefit. The branch of service forwards the certified claim as denied to OSGLI along with a copy of the original denial letter.

First Level of Appeal - Reconsideration
The member decides to appeal and does so in writing with a 1st Notice of Disagreement to their branch of service point of contact. The member's appeal goes through the first level of the internal review process within their branch of service. This process is called a reconsideration and is done within the branch of service TSGLI office.

- If the decision is made to overturn the original denial decision on the certified claim, the claim is re-certified to OSGLI and the claim is paid.
- If the decision is made to uphold the original denial decision on the certified claim, the member is sent a letter by their branch of service informing them of the decision and the next steps they can take to appeal the decision.

Second Level of Appeal
If the member decides to appeal further, they need to submit a 2nd Notice of Disagreement to their branch of service point of contact. The member's appeal goes through the second level of the internal review process within their branch of service.

- If the decision is made to overturn the original denial decision on the certified claim, the claim is re-certified to OSGLI and the claim is paid.
- If the decision is made to uphold the original denial decision on the certified claim, the member is sent a letter by their branch of service informing them of the decision and the next steps they can take to appeal the decision.

Third Level of Appeal
If the member decides to appeal further, they need to submit a 3rd Notice of Disagreement to their branch of service point of contact. The member's appeal goes through the third level of the internal review process within their branch of service.

- If the decision is made to overturn the original denial decision on the certified claim, the claim is re-certified to OSGLI and the claim is paid.
- If the decision is made to uphold the original denial decision on the certified claim, the member is sent a letter informing them of the decision and informing them that their last resort in the appeal process is suing in federal court.

Sending Information to OSGLI
The branch of service appeals point of contact sends information to OSGLI's appeals email box at each stage of the appeal process and OSGLI enters it into their claims system. The member has the option to sue in federal court on the denial of a TSGLI benefit at anytime.

Part 9 - Appendices

Appendix A – Schedule of Losses

For losses listed in Part I, multiple injuries resulting from a single traumatic event may be combined with each other and treated as one loss for purposes of a single payment (except where noted otherwise), however, the total payment amount **MAY NOT** exceed $100,000.

For losses listed in Part II, payment amounts **MAY NOT** be combined with payment amounts in Part I - only the higher amount will be paid. The total payment amount **MAY NOT** exceed $100,000 for multiple injuries resulting from a single traumatic event.

Part I

Loss	Payment Amount
1. **Sight:** Total and permanent loss of sight **OR** loss of sight that has lasted 120 days • For each eye	$50,000
2. **Hearing:** Total and permanent loss of hearing • For one ear • For both ears	 $25,000 $100,000
3. **Speech:** Total and permanent loss of speech	$50,000
4. **Quadriplegia**: complete paralysis of all four limbs	$100,000
5. **Hemiplegia**: complete paralysis of the upper and lower limbs on one side of the body	$100,000
6. **Paraplegia:** complete paralysis of both lower limbs	$100,000
7. **Uniplegia**: complete paralysis of one limb* **Note: Payment for uniplegia of arm cannot be combined with loss 9, 10 or 14 for the same arm. Payment for uniplegia of leg cannot be combined with loss 11, 12, 13 or 15 for the same leg.*	$50,000
8. **Burns:** 2nd degree or worse burns to at least 20% of the body including the face **OR**, at least 20% of the face	$100,000
9. **Amputation of hand:** Amputation at or above the wrist • For each hand* *Note: Payment for loss 9 cannot be combined with payment for loss 10 for the same hand.	$50,000
10. **Amputation of 4 fingers on 1 hand OR thumb alone**: Amputation at or above the metacarpophalangeal joint • For each hand	$50,000
11. **Amputation of foot:** Amputation at or above the ankle • For each foot* *Note: Payment for loss 11 cannot be combined with payments for losses 12 or 13 for the same foot.	$50,000
12. **Amputation of all toes including the big toe on 1 foot**: Amputation at or above the metatarsophalangeal joint • For each foot **Note: Payment for loss 12 cannot be combined with payments for loss 13 for the same foot.*	$50,000

Loss	Payment Amount
13. Amputation of big toe only, OR other 4 toes on 1 foot: Amputation at or above the metatarsophalangeal joint ▪ For each foot	$25,000
14. Limb salvage of arm: Salvage of arm in place of amputation • For each arm* **Note: Payment for loss 14 cannot be combined with payments for losses 7, 9 or 10 for the same arm.*	$50,000
15. Limb salvage of leg: Salvage of leg in place of amputation • For each leg* **Note: Payment for loss 15 cannot be combined with payments for losses 7, 11, 12 or 13 for the same leg.*	$50,000
16. Facial Reconstruction – reconstructive surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects.	
▪ **Jaw –** surgery to correct discontinuity loss of the upper or lower jaw	$75,000
▪ **Nose –** surgery to correct discontinuity loss of 50% or more of the cartilaginous nose	$50,000
▪ **Lips –** surgery to correct discontinuity loss of 50% or more of the upper or lower lip - For one lip - For both lips	 $50,000 $75,000
▪ **Eyes –** surgery to correct discontinuity loss of 30% or more of the periorbita - For each eye	 $25,000
▪ **Facial Tissue** – surgery to correct discontinuity loss of the tissue in 50% or more of any of the following facial subunits: forehead, temple, zygomatic, mandibular, infraorbital or chin. - For each facial subunit Note 1: Injuries listed under facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000. Note 2: Any injury or combination of injuries under facial reconstruction may also be combined with other injuries listed in Part I and treated as one loss, provided that all injuries are the result of a single traumatic event. However, the total payment amount may not exceed $100,000.	**$**25,000
17. Coma from traumatic injury AND/OR **Traumatic Brain Injury resulting in inability to perform at least 2 Activities of Daily Living (ADL)** ▪ at 15th consecutive day of coma or ADL loss ▪ at 30th consecutive day of coma or ADL loss ▪ at 60th consecutive day of coma or ADL loss ▪ at 90th consecutive day of coma or ADL loss	 $25,000 an additional $25,000 an additional $25,000 an additional $25,000

Loss	Payment Amount
18. Hospitalization due to traumatic brain injury ▪ at 15th consecutive day of hospitalization *Note 1: Payment for hospitalization replaces the first payment period in loss 17.* *Note 2: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in § 9.20(e)(6)(xiii), admitted to the facility, transferred between facilities, and released from the facility.*	$25,000
19. Genitourinary Losses	
▪ **Anatomical loss of the penis** Anatomical loss of the penis is defined as amputation of the glans penis or any portion of the shaft of the penis above the glans penis (i.e. closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery.	$50,000
▪ **Permanent loss of use of the penis** Permanent loss of use of the penis is defined as damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.	$50,000
▪ **Anatomical loss of one testicle** Anatomical loss of the testicle(s) is defined as the amputation of, or damage to, one or both testicles that requires testicular salvage, reconstructive surgery, or both.	$25,000
▪ **Anatomical loss of both testicles** See above – Same definition as anatomical loss of one testicle	$50,000
▪ **Permanent loss of use of both testicles** Permanent loss of use of both testicles is defined as damage to both testicles resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.	$50,000
▪ **Anatomical loss of the vulva, uterus, or vaginal canal** Anatomical loss of the vulva, uterus, or vaginal canal is defined as the complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery.	$50,000
▪ **Permanent loss of use of the vulva or vaginal canal** Permanent loss of use of the vulva or vaginal canal is defined as damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse that is reasonably certain to continue throughout the lifetime of the member.	$50,000
▪ **Anatomical loss of one ovary** Anatomical loss of the ovary(ies) is defined as the amputation of one or both ovaries or damage to one or both ovaries that requires ovarian salvage, reconstructive surgery, or both.	$25,000
▪ **Anatomical loss of both ovaries** See above – Same definition as anatomical loss of one ovary	$50,000

Loss	Payment Amount
▪ **Permanent loss of use of both ovaries** Permanent loss of use of both ovaries is defined as damage to both ovaries resulting in the need for hormonal replacement therapy that is medically required and reasonably certain to continue throughout the lifetime of the member.	$50,000
▪ **Total and permanent loss of urinary system function** Total and permanent loss of urinary system function is defined as damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis, either of which is reasonably certain to continue throughout the lifetime of the member.	$50,000
Note 1: Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000. Note 2: Any genitourinary loss may be combined with other (TSGLI) injuries listed in § 9.20(f)(1) through (18) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment may not exceed $100,000.	

Part II

Loss	Payment Amount
20. Traumatic injury resulting in inability to perform at least 2 Activities of Daily Living (ADL)	
▪ at 30th consecutive day of ADL loss	$25,000
▪ at 60th consecutive day of ADL loss	an additional $25,000
▪ at 90th consecutive day of ADL loss	an additional $25,000
▪ at 120th consecutive day of ADL loss	an additional $25,000
21. Hospitalization due to traumatic injury ▪ at 15th consecutive day of hospitalization *Note 1: Payment for hospitalization replaces the first payment period in loss20.* *Note 2: Duration of hospitalization includes dates on which member is transported from the injury site to a facility described in §8), admitted to the facility, transferred between facilities, and released from the facility.*	$25,000

Appendix B – Glossary of Terms

Activities of Daily Living (ADL) - routine self-care activities that a person normally performs every day without needing assistance. The six basic ADL are eating, bathing, dressing, toileting, transferring and continence.

Avulsion - a wound caused by the tearing away of tissues, bones, and/or cartilage.

Direct Result– Direct result means there must be a clear connection between the traumatic event and resulting loss and no other factor, aside from the traumatic event, can play a part in causing the loss.

Discontinuity Defects - injuries of the face or jaw that result in open wounds with large separations or gaps in the major facial or jaw features.

External Force - An external force is a rush of force or uncontrolled power that causes an individual to meet involuntarily and violently with an object, matter, or entity that causes the individual harm.

Facial Reconstruction - surgery to correct traumatic avulsions of the face or jaw that cause discontinuity defects

Genitourinary – of or pertaining to the genitals and urinary organs.

Hemiplegia - the complete and irreversible paralysis of the upper and lower limbs on one side of the body caused by damage to the spinal cord or associated nerves, or to the brain.

Hospital - an inpatient facility accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations. This includes Combat Support Hospitals, Air Force Theater Hospitals and Navy Hospital Ships.

Limb - an arm or leg with all of its associated parts

Limb Salvage - A series of operations designed to save an arm or leg rather than amputate.

Medical Professional - a licensed practitioner of the healing arts acting within the scope of his or her license. Some examples include a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

Paraplegia - the complete and irreversible paralysis of both lower limbs caused by damage to the spinal cord or associated nerves, or to the brain.

Pyogenic infection – a pus forming infection, often from a wound.

Quadriplegia - the complete and irreversible paralysis of all four limbs caused by damage to the spinal cord or associated nerves, or to the brain.

Traumatic Event - the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to a living body.
The event must involve a physical impact upon an individual. Some examples would include: an airplane crash, a fall in the bathtub, or a brick that falls and causes a sudden blow to the head. It would not include an injury that is induced by the stress or strain of the normal work effort that is employed by an individual, such as straining one's back from lifting a ladder.

Traumatic Injury - the physical damage to a living body that results from a traumatic event.

Uniplegia - the complete and irreversible paralysis of one limb of the body caused by damage to the spinal cord or associated nerves, or to the brain.

Appendix C –TSGLI Points of Contact

TSGLI Policy Questions Point of Contact

Karen Naccarelli
Chief, Program Administration and Oversight Staff
Veterans Affairs Regional Office and Insurance Center
5000 Wissahickon Ave
Philadelphia, PA 19144
(215) 842-2000, extension 4404
karen.naccarelli@va.gov

Branch of Service Points of Contact

Service Branch	General Information	Claims Information
Army (All Components**)**	**Phone:** (800) 237-1336, Option 4 **Email**: usarmy.knox.hrc.mbx.tagd-tsgli-claims@mail.mil	**Submit Claims via fax:** (502) 613-4513 **Submit Claims via email:** usarmy.knox.hrc.mbx.tagd-tsgli-claims@mail.mil **Submit Claims via postal mail:** U.S. Army Human Resources Command ATTN: AHRC-PDR--C, (TSGLI) 1600 Spearhead Division Avenue - Dept 420 Ft. Knox, KY 40122-5402
Navy	**Phone:** (866) 827-5672 (option 2)/ 901-874-6662 DSN 882 **Email**:MILL_TSGLI@navy.mil	**Submit Claims via fax:** (901) 874-2265 **Submit Claims via email:** MILL_TSGLI@navy.mil **Submit Claims via postal mail:** Commander, Navy Personnel Command Attn: PERS-13 5720 Integrity Drive, Millington, TN 38055-1300
Air Force (Active Duty)	**Phone**: (800) 433-0048 **Email:** afpc.casualty@us.af.mil	**Submit Claims via fax:** (210) 565-6271 **Submit Claims via email:** afpc.casualty@us.af.mil **Submit Claims via postal mail:** AFPC/DPWC 550 C Street West, Suite 14 Randolph AFB, TX 78150-4716

Service Branch	General Information	Claims Information
Air Force Reserves	**Phone:** (800) 525-0102 **Email:** casualty. casualty.arpc1@us.af.mil	**Submit Claims via fax:** (720) 847-3887 **Submit Claims via email:** casualty.arpc1@us.af.mil **Submit Claims via postal mail:** HQ, ARPC/DPTTB 18420 E. Silver Creek Ave BLDG 390 MS 68 Buckley AFB, CO 80011
Air National Guard	**Phone:** (240) 612-9151 or (240) 612-9128 **Email:** usaf.jbanafw.ngb-a1.mbx.a1ps@mail.mil	**Submit Claims via email:** usaf.jbanafw.ngb-a1.mbx.a1ps@mail.mil **Submit Claims via postal mail:** NGB/A1PS TSGLI Program Manager 3500 Fetchet Ave. 2nd Floor Joint Base Andrews, MD 20762-5157
US Marine Corps	**Phone:** (877) 216-0825 or (703) 432-9277 **Email:** t-sgli@usmc.mil	**Submit Claims via fax:** (800) 770-9968 **Submit Claims via email:** t-sgli@usmc.mil **Submit Claims via postal mail:** HQ, Marine Corps Attn: WWR-TSGLI 1998 Hill Street Quantico, VA 22134
Coast Guard	**Phone:** 202-795-6647 **Email:** ARL-PF-CGPSC-PSDFS-COMPENSATION@uscg.mil	**Submit Claims via fax:** 202-372-8488/8323 ATTN: Casualty Chief (PSC-PSD-FS-Casualty)**Submit Claims via email:** ARL-PF-CGPSC-PSDFS-COMPENSATION@uscg.mil **Submit Claims via postal mail:** COMMANDER CG PERSONNEL SERVICE CENTER PSC ATTN: CASUALTY CHIEF, PSC-PSD-FS-CASUALTY US COAST GUARD STOP 7200 2703 MARTIN LUTHER KING JR AVE SE WASHINGTON DC 20593-7200

Service Branch	General Information	Claims Information
Public Health Service	**Phone:** (301) 427-3280 **Email:** CompensationBranch@psc.hhs.gov	**Submit Claims via fax:** (301) 427-3431 or (301) 427-3432 **Submit Claims via email:** CompensationBranch@psc.hhs.gov **Submit Claims via postal mail:** PHS Compensation Branch Parklawn Building 5600 Fishers Lane, Rm 4-50 Rockville, MD 20857
NOAA Corps	**Phone:** (301) 713-3444 **Email:** director.cpc@noaa.gov	**Submit Claims via fax:** (301) 713-4140 **Submit Claims via email:** director.cpc@noaa.gov **Submit Claims via postal mail:** US Dept. of Commerce, NOAA 8403 Colesville Rd, Suite 500, 5th Floor Silver Spring MD 20910

Appendix D – Branch of Service Appeals Point of Contact List

All initial appeals should be sent to the branch of service TSGLI office shown on the front of the TSGLI claim form. The branch of service TSGLI office will review any additional information sent on an initial appeal and make a second determination of eligibility on the claim. If the case is appealed after this initial review, the following offices within each branch review the appeals.

Branch of Service Appeals

Branch of Service	Mailing Addresses to Send 2nd Level Appeals	Mailing Addresses to Send 3rd Level Appeals
Army – Active and Reserve	U.S. Army Human Resources Command ATTN : AHRC-PDR-C, Dept 420 1600 Spearhead Division Avenue Fort Knox, KY 40122-5402	Army Review Boards Agency (ARBA) Attn: Assistant Operations Officer 1901 South Bell Street, 2nd floor Arlington, Virginia 22202-4508
Navy – Active and Reserve	TSGLI Appeals Board Navy Council of Review Boards 720 Kennon Street S.E., Room 309 Washington Navy Yard, D.C. 20374-5023	Board for Correction of Naval Records 701 South Courthouse Road Suite 1001 Arlington, VA 22204-2490
Air Force Active	AFPC/DPFCS 550 C. Street West Joint Base San Antonio-Randolph, TX 78150	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Air Force Reserve (Non-Active Duty)	USAF Physical Disability Division HQ ARPC/DPTTB 18420 E. Silver Creek Ave BLDG 390 MS 68 Buckley AFB, CO 80011	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Air National Guard	Air Force Surgeon General NGB/A1PS, TSGLI Program Manager 3500 Fetchet Ave. 2nd Floor Joint Base Andrews, MD 20762-5157	Board for Correction of Air Force Records SAF/MRBR 550-C Street West, Suite 40 Randolph AFB, TX 78150-4742
Marines	TSGLI Appeals Board Navy Council of Review Boards 720 Kennon St SE Ste 309 Washington Navy Yard, DC 20374-5023	Director Navy Council of Review Boards 720 Kennon Street S.E., Room 309 Washington Navy Yard, D.C. 20374-5023
Coast Guard		
Public Health Service		

Branch of Service	Mailing Addresses to Send 2nd Level Appeals	Mailing Addresses to Send 3rd Level Appeals
National Oceanic and Atmospheric Administration Corps		